

STATE OF COLORADO
Department of Health Care Policy and Financing
Contract with
Rocky Mountain Health Maintenance Organization, Inc.
for
ACC Payment Reform Pilot Program

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1. PARTIES

This Contract (hereinafter called “Contract”) is entered into by and between Rocky Mountain Health Maintenance Organization, Inc., (hereinafter called “Contractor”), and the STATE OF COLORADO acting by and through the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203 (hereinafter called the “State” or “Department”). Contractor and the State hereby agree to the following terms and conditions.

2. EFFECTIVE DATE AND NOTICE OF NONLIABILITY

This Contract shall not be effective or enforceable until it is approved and signed by the Colorado State Controller or designee and approved by the Centers for Medicare & Medicaid Services (CMS) (hereinafter called the “Effective Date”). The State shall not be liable to pay or reimburse Contractor for any performance hereunder including, but not limited to, costs or expenses incurred, or be bound by any provision hereof prior to the Effective Date.

3. RECITALS

A. Authority, Appropriation, and Approval

Authority to enter into this Contract exists in CRS 25.5-1-101 et. seq. and funds have been budgeted, appropriated and otherwise made available and a sufficient unencumbered balance thereof remains available for payment. Required approvals, clearance and coordination have been accomplished from and with appropriate agencies.

B. Consideration

The Parties acknowledge that the mutual promises and covenants contained herein and other good and valuable consideration are sufficient and adequate to support this Contract.

C. Purpose

The purpose of this Contract is to create a new payment reform pilot program within the Accountable Care Collaborative. Contractor’s offer, submitted in response to Request for Proposal (RFP) Number HB12-1281PRI was selected by the State.

D. References

All references in this Contract to sections (whether spelled out or using the §symbol), subsections, exhibits or other attachments, are references to sections, subsections, exhibits or other attachments contained herein or incorporated as a part hereof, unless otherwise noted.

4. DEFINITIONS

The following terms as used herein shall be construed and interpreted as follows:

- A. “Closeout Period” means the period of time defined in Exhibit A, Statement of Work.
- B. “Contract” means this Contract, its terms and conditions, attached addenda, exhibits, documents incorporated by reference under the terms of this Contract, and any future modifying agreements, exhibits, attachments or references incorporated herein pursuant to Colorado State law, Fiscal Rules, and State Controller Policies.
- C. Exhibits and other Attachments. The following documents are attached hereto and incorporated by reference herein:
 - HIPAA Business Associate Addendum
 - Exhibit A, Statement of Work
 - Exhibit B, Covered Services
 - Exhibit C, Monthly Payment Rates
 - Exhibit D, Flat File Specifications
 - Exhibit E, Administrative and Medical Services
 - Exhibit F, Covered Behavioral Health Procedure Codes
 - Exhibit G, Contractor Disclosure Template
 - Exhibit H, Encounter Data Specifications
 - Exhibit I, Medical Home Model Principles
 - Exhibit J, Serious Reportable or Never Events
 - Exhibit K, Member Information
 - Exhibit L, Family Planning Documentation Methodology and Reporting
 - Exhibit M, Care Coordination Levels
 - Exhibit N, Disproportionate Share and Graduate Medical Education Hospital Reporting
 - Exhibit O, Medical Loss Ratio (MLR) Calculation Template
 - Exhibit P, Sample Option Letter
- D. “Goods” means tangible material acquired, produced, or delivered by Contractor either separately or in conjunction with the Services Contractor renders hereunder.
- E. “Party” means the State or Contractor and Parties means both the State and Contractor.
- F. “Review” means examining Contractor’s Work to ensure that it is adequate, accurate, correct, and in accordance with the standards described in this Contract.
- G. “Services” means the required services to be performed by Contractor pursuant to this Contract.
- H. “State Fiscal Year” or “SFY” means the twelve (12) month period beginning on July 1st of a year and ending on June 30th of the following year.
- I. “Subcontractor” means third-parties, if any, engaged by Contractor to aid in performance of its obligations.

- J. “Work” means the tasks and activities Contractor is required to perform to fulfill its obligations under this Contract, including the performance of the Services and delivery of the Goods.
- K. “Work Product” means the tangible or intangible results of Contractor’s Work, including, but not limited to, software, research, reports, studies, data, photographs, negatives or other finished or unfinished documents, drawings, models, surveys, maps, materials, or work product of any type, including drafts.

Any terms used herein which are defined in Exhibit A, Statement of Work shall be construed and interpreted as defined therein.

5. TERM

A. Initial Term

The Parties’ respective performances under this Contract shall commence on the the Effective Date. This Contract shall expire on June 30, 2016, unless sooner terminated or further extended as specified elsewhere herein.

B. Two Month Extension

The State, at its sole discretion, upon written notice to Contractor as provided in **§16**, may unilaterally extend the term of this Contract for a period not to exceed two months if the Parties desire to continue the services and a replacement Contract has not been fully executed by the expiration of any initial term or renewal term. The provisions of this Contract in effect when such notice is given, including, but not limited to, prices, rates and delivery requirements, shall remain in effect during the two month extension. The two (2) month extension shall immediately terminate when and if a replacement contract is approved and signed by the Colorado State Controller or an authorized designee, or at the end of two (2) months, whichever is earlier.

C. Option to Extend

The State may require continued performance for a period of one (1) year or less at the same rates and same terms specified in the Contract. If the State exercises this option, it shall provide written notice to Contractor at least thirty (30) days prior to the end of the current Contract term in form substantially equivalent to **Exhibit P**. If exercised, the provisions of the Option Letter shall become part of and be incorporated into this Contract. In no event shall the total duration of this Contract, from the Operational Start Date until termination and including the exercise of any options under this clause, exceed five (5) years, unless the State receives approval from the State Purchasing Director or delegate.

6. STATEMENT OF WORK

A. Completion

Contractor shall complete the Work and its other obligations as described in this Contract on or before the end of the term of this Contract. The State shall not be

liable to compensate Contractor for any Work performed prior to the Effective Date or after the expiration or termination of this Contract.

B. Goods and Services

Contractor shall procure Goods and Services necessary to complete the Work. Such procurement shall not increase the maximum amount payable hereunder by the State.

C. Independent Contractor

All persons employed by Contractor or Subcontractors to perform Work under this Contract shall be Contractor's or Subcontractors' employee(s) for all purposes hereunder and shall not be employees of the State for any purpose as a result of this Contract.

7. PAYMENTS TO CONTRACTOR

The State shall, in accordance with the provisions of this §7 and **Exhibit A**, Statement of Work, pay Contractor in the amounts and using the methods set forth below:

A. Maximum Payment

In no circumstance shall any payment under this Contract exceed the upper limit of payment for Nonrisk Contracts, as described in 42 CFR §447.362.

B. Payment

Payment pursuant to this Contract will be made as earned.

C. Interest

The State shall not pay interest on any amounts due to Contractor hereunder.

D. Available Funds-Contingency-Termination

The State is prohibited by law from making commitments beyond the term of the State's current fiscal year. Therefore, Contractor's compensation beyond the State's current fiscal year is contingent upon the continuing availability of State appropriations as provided in the Colorado Special Provisions, set forth below. If federal funds are used to fund this Contract, in whole or in part, the State's performance hereunder is contingent upon the continuing availability of such funds. Payments pursuant to this Contract shall be made only from available funds and the State's liability for such payments shall be limited to the amount remaining of such available funds. If State or federal funds are not appropriated, or otherwise become unavailable to fund this Contract, the State may terminate this Contract immediately, in whole or in part, without further liability notwithstanding any notice and cure period in **§14.B**.

E. Erroneous Payments

Payments made to Contractor in error for any reason, including, but not limited to, overpayments or improper payments, may be recovered from Contractor by deduction from subsequent payments under this Contract or by other appropriate

methods and collected as a debt due to the State. Such funds shall not be paid to any party other than the State.

F. Closeout Payments

Notwithstanding anything to the contrary in this Contract, all payments for the final month of the Contract shall be paid to the Contractor no sooner than ten (10) days after the Department has determined that the Contractor has completed all of the requirements of the Closeout Period.

G. Option to Increase or Decrease Statewide Quantity of Service

The Department may increase or decrease the statewide quantity of services described in the Contract based upon the rates established in the Contract. If the Department exercises the option, it will provide written notice to Contractor in a form substantially equivalent to **Exhibit P**. Delivery/performance of services shall continue at the same rates and terms. If exercised, the provisions of the Option Letter shall become part of and be incorporated into the original Contract.

8. REPORTING NOTIFICATION

Reports required under this Contract shall be in accordance with the procedures and in such form as prescribed by the State and as described in **Exhibit A**.

A. Litigation Reporting

Within ten (10) days after being served with any pleading in a legal action filed with a court or administrative agency, related to this Contract or which may affect Contractor's ability to perform its obligations hereunder, Contractor shall notify the State of such action and deliver copies of such pleadings to the State's principal representative as identified herein. If the State's principal representative is not then serving, such notice and copies shall be delivered to the Executive Director of the Department.

B. Noncompliance

Contractor's failure to provide reports and notify the State in a timely manner in accordance with this §8 may result in the delay of payment of funds and/or termination as provided under this Contract.

9. CONTRACTOR RECORDS

A. Maintenance

Contractor shall make, keep, maintain, and allow inspection and monitoring by the State of a complete file of all records, documents, communications, notes, and other written materials, electronic media files and electronic communications, pertaining in any manner to the Work or the delivery of Services or Goods hereunder. Contractor shall maintain such records until the last to occur of: **(i)** a period of six (6) years after the date this Contract expires or is sooner terminated, or **(ii)** a period of six (6) years after final payment is made hereunder, or **(iii)** a period of six (6) years after the resolution of any pending Contract matters, or **(iv)** if an audit is occurring, or Contractor has received notice that an audit is pending, until such

audit has been completed and its findings have been resolved (collectively, the “Record Retention Period”). All such records, documents, communications and other materials shall be the property of the State, and shall be maintained by the Contractor in a central location and the Contractor shall be custodian on behalf of the State.

B. Inspection

Contractor shall permit the State, the federal government and any other duly authorized agent of a governmental agency to audit, inspect, examine, excerpt, copy and/or transcribe Contractor's records related to this Contract during the Record Retention Period, to assure compliance with the terms hereof or to evaluate performance hereunder. The State reserves the right to inspect the Work at all reasonable times and places during the term of this Contract, including any extensions or renewals. If the Work fails to conform with the requirements of this Contract, the State may require Contractor promptly to bring the Work into conformity with Contract requirements, at Contractor’s sole expense. If the Work cannot be brought into conformance by re-performance or other corrective measures, the State may require Contractor to take necessary action to ensure that future performance conforms to Contract requirements and exercise the remedies available under this Contract, at law or in equity, in lieu of or in conjunction with such corrective measures.

C. Monitoring

Contractor shall permit the State, the federal government and any other duly authorized agent of a government agency, in their sole discretion, to monitor all activities conducted by Contractor pursuant to the terms of this Contract using any reasonable procedure, including, but not limited to: internal evaluation procedures, examination of program data, special analyses, on-site checking, formal audit examinations, or any other procedure. All monitoring controlled by the State shall be performed in a manner that shall not unduly interfere with Contractor’s performance hereunder.

D. Final Audit Report

If an audit is performed on Contractor’s records for any fiscal year covering a portion of the term of this Contract, Contractor shall submit a copy of the final audit report to the State or its principal representative at the address specified herein.

10. CONFIDENTIAL INFORMATION

Contractor shall comply with the provisions of this §10 if it becomes privy to confidential information in connection with its performance hereunder. Confidential information includes, but is not necessarily limited to, any state records, personnel records, and information concerning individuals. Such information shall not include information required to be disclosed pursuant to the Colorado Open Records Act, CRS §24-72-101, et seq.

A. Confidentiality

Contractor shall keep all State records and information confidential at all times and comply with all laws and regulations concerning confidentiality of information. Any request or demand by a third party for State records and information in the possession of Contractor shall be immediately forwarded to the State's principal representative.

B. Health Insurance Portability & Accountability Act of 1996 ("HIPAA")

i. Federal Law and Regulations

Pursuant to federal law and regulations governing the privacy of certain health information, the Contractor, to the extent applicable, shall comply with the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §1320d – 1320d-8 ("HIPAA") and its implementing regulations promulgated by the U.S. Department of Health and Human Services, 45 C.F.R. Parts 160 and 164 (the "Privacy Rule") and other applicable laws, as amended.

ii. Business Associate Contract

Federal law and regulations governing the privacy of certain health information requires a "Business Associate Contract" between the State and the Contractor, 45 C.F.R. Section 164.504(e). Attached and incorporated herein by reference and agreed to by the parties is a HIPAA Business Associate Addendum ("Addendum") for HIPAA compliance. Terms of the Addendum shall be considered binding upon execution of this Contract and shall remain in effect during the term of the Contract including any extensions.

iii. Confidentiality of Records

Whether or not an Addendum is attached to this Contract, the Contractor shall protect the confidentiality of all records and other materials containing personally identifying information that are maintained in accordance with the Contract and comply with HIPAA rules and regulations. Except as provided by law, no information in possession of the Contractor about any individual constituent shall be disclosed in a form including identifying information without the prior written consent of the person in interest, a minor's parent, or guardian. The Contractor shall have written policies governing access to, duplication and dissemination of, all such information. The Contractor shall advise its employees, agents and Subcontractors, if any, that they are subject to these confidentiality requirements. The Contractor shall provide its employees, agents and Subcontractors, if any, with a copy or written explanation of these confidentiality requirements before access to confidential data is permitted. No confidentiality requirements contained in this Contract shall negate or supersede the provisions of the federal Health Insurance Portability and Accountability Act of 1996.

C. Notification

Contractor shall notify its agents, employees, Subcontractors and assigns who may come into contact with State records or other confidential information that each is subject to the confidentiality requirements set forth herein, and shall provide each with a written explanation of such requirements before permitting them to access such records and information.

D. Use, Security, and Retention

Confidential information of any kind shall not be distributed or sold to any third party or used by Contractor or its agents in any way, except as authorized by this Contract or approved in writing by the State. Contractor shall provide and maintain a secure environment that ensures confidentiality of all State records and other confidential information wherever located. Confidential information shall not be retained in any files or otherwise by Contractor or its agents, except as permitted in this Contract or approved in writing by the State.

E. Disclosure-Liability

Disclosure of State records or other confidential information by Contractor for any reason may be cause for legal action by third parties against Contractor, the State or their respective agents. Contractor shall indemnify, save, and hold harmless the State, its employees and agents, against any and all claims, damages, liability and court awards including costs, expenses, and attorney fees and related costs, incurred as a result of any act or omission by Contractor, or its employees, agents, Subcontractors, or assignees pursuant to this §10.

11. CONFLICTS OF INTEREST

A. Contractor shall not engage in any business or personal activities or practices or maintain any relationships which conflict in any way with the full performance of Contractor's obligations hereunder. Contractor acknowledges that with respect to this Contract, even the appearance of a conflict of interest is harmful to the State's interests. Absent the State's prior written approval, Contractor shall refrain from any practices, activities or relationships that reasonably appear to be in conflict with the full performance of Contractor's obligations to the State hereunder. If a conflict or appearance exists, or if Contractor is uncertain whether a conflict or the appearance of a conflict of interest exists, Contractor shall submit to the State a disclosure statement setting forth the relevant details for the State's consideration. Failure to promptly submit a disclosure statement or to follow the State's direction in regard to the apparent conflict constitutes a breach of this Contract.

B. The Contractor (and Subcontractors or subgrantees permitted under the terms of this Contract) shall maintain a written code of standards governing the performance of its employees engaged in the award and administration of contracts. No employee, officer or agent of the Contractor, Subcontractor, or subgrantee shall participate in the selection, or in the award or administration of a contract or subcontract supported by federal funds if a conflict of interest, real or apparent, would be involved. Such a conflict would arise when:

- i. The employee, officer or agent;
- ii. Any member of the employee's immediate family;
- iii. The employee's partner; or
- iv. An organization which employs, or is about to employ, any of the above, has a financial or other interest in the firm selected for award. The Contractor's, Subcontractor's, or subgrantee's officers, employees, or agents will neither solicit nor accept gratuities, favors, or anything of monetary value from Contractors, potential Contractors, or parties to subagreements.

12. REPRESENTATIONS AND WARRANTIES

Contractor makes the following specific representations and warranties, each of which was relied on by the State in entering into this Contract.

A. Standard and Manner of Performance

Contractor shall perform its obligations hereunder in accordance with the highest standards of care, skill and diligence in Contractor's industry, trade, or profession and in the sequence and manner set forth in this Contract.

B. Legal Authority – Contractor Signatory

Contractor warrants that it possesses the legal authority to enter into this Contract and that it has taken all actions required by its procedures, and bylaws, and/or applicable laws to exercise that authority, and to lawfully authorize its undersigned signatory to execute this Contract, or any part thereof, and to bind Contractor to its terms. If requested by the State, Contractor shall provide the State with proof of Contractor's authority to enter into this Contract within five (5) days of receiving such request.

C. Licenses, Permits, Etc.

Contractor represents and warrants that as of the Effective Date it has, and that at all times during the term hereof it shall have and maintain, at its sole expense, all licenses, certifications, approvals, insurance, permits and other authorizations required by law to perform its obligations hereunder. Contractor warrants that it shall maintain all necessary licenses, certifications, approvals, insurance, permits, and other authorizations required to properly perform this Contract, without reimbursement by the State or other adjustment in the Contract. Additionally, all employees, agents, and Subcontractors of Contractor performing Services under this Contract shall hold all required licenses or certifications, if any, to perform their responsibilities. Contractor, if a foreign corporation or other foreign entity transacting business in the State of Colorado, further warrants that it currently has obtained and shall maintain any applicable certificate of authority to transact business in the State of Colorado and has designated a registered agent in Colorado to accept service of process. Any revocation, withdrawal or non-renewal of licenses, certifications, approvals, insurance, permits or any such similar requirements necessary for Contractor to properly perform the terms of this Contract is a material breach by Contractor and constitutes grounds for termination of this Contract.

13. INSURANCE

Contractor and its Subcontractors shall obtain and maintain insurance as specified in this section at all times during the term of this Contract. All policies evidencing the insurance coverage required hereunder shall be issued by insurance companies satisfactory to Contractor and the State.

A. Contractor

i. Public Entities

If Contractor is a "public entity" within the meaning of the Colorado Governmental Immunity Act, CRS §24-10-101, et seq., as amended (the "GIA"), then Contractor shall maintain at all times during the term of this Contract such liability insurance, by commercial policy or self-insurance, as is necessary to meet its liabilities under the GIA. Contractor shall show proof of such insurance satisfactory to the State, if requested by the State. Contractor shall require each contract with a Subcontractor that is a public entity, to include the insurance requirements necessary to meet such Subcontractor's liabilities under the GIA.

ii. Non-Public Entities

If Contractor is not a "public entity" within the meaning of the GIA, Contractor shall obtain and maintain during the term of this Contract insurance coverage and policies meeting the requirements set forth in **§13.B.**

B. Contractors – Subcontractors

Contractor shall require each contract with Subcontractors other than those that are public entities, providing Goods or Services in connection with this Contract, to include insurance requirements substantially similar to the following:

i. Worker's Compensation

Worker's Compensation Insurance as required by State statute, and Employer's Liability Insurance covering all of Contractor's or Subcontractor's employees acting within the course and scope of their employment.

ii. General Liability

Commercial General Liability Insurance written on ISO occurrence form CG 00 01 10/93 or equivalent, covering premises operations, fire damage, independent contractors, products and completed operations, blanket contractual liability, personal injury, and advertising liability with minimum limits as follows:

- a. \$1,000,000 each occurrence;
- b. \$1,000,000 general aggregate;
- c. \$1,000,000 products and completed operations aggregate; and
- d. \$50,000 any one fire.

If any aggregate limit is reduced below \$1,000,000 because of claims made or paid, Subcontractor shall immediately obtain additional insurance to restore the full aggregate limit and furnish to Contractor a certificate or other document satisfactory to Contractor showing compliance with this provision.

iii. Protected Health Information Insurance

Liability insurance covering all loss of Protected Health Information data and claims based upon alleged violations of privacy rights through improper use or disclosure of Protected Health Information with minimum limits as follows:

- a. \$1,000,000 each occurrence; and
- b. \$2,000,000 general aggregate.

iv. Automobile Liability

Automobile Liability Insurance covering any auto (including owned, hired and non-owned autos) with a minimum limit of \$1,000,000 each accident combined single limit.

v. Additional Insured

The State shall be named as additional insured on all Commercial General Liability and protected health information insurance policies (leases and construction contracts require additional insured coverage for completed operations on endorsements CG 2010 11/85, CG 2037, or equivalent) required of Contractor and any Subcontractors hereunder.

vi. Primacy of Coverage

Coverage required of Contractor and Subcontractor shall be primary over any insurance or self-insurance program carried by Contractor or the State.

vii. Cancellation

The above insurance policies shall include provisions preventing cancellation or non-renewal without at least 30 days prior notice to Contractor and Contractor shall forward such notice to the State in accordance with **§16** (Notices and Representatives) within seven days of Contractor's receipt of such notice.

viii. Subrogation Waiver

All insurance policies in any way related to this Contract and secured and maintained by Contractor or its Subcontractors as required herein shall include clauses stating that each carrier shall waive all rights of recovery, under subrogation or otherwise, against Contractor or the State, its agencies, institutions, organizations, officers, agents, employees, and volunteers.

C. Certificates

Contractor and all Subcontractors shall provide certificates showing insurance coverage required hereunder to the State within seven (7) business days of the

Effective Date of this Contract. No later than fifteen (15) days prior to the expiration date of any such coverage, Contractor and each Subcontractor shall deliver to the State or Contractor certificates of insurance evidencing renewals thereof. In addition, upon request by the State at any other time during the term of this Contract or any subcontract, Contractor and each Subcontractor shall, within ten (10) days of such request, supply to the State evidence satisfactory to the State of compliance with the provisions of this §13.

14. BREACH

A. Defined

In addition to any breaches specified in other sections of this Contract, the failure of the Contractor to perform any of its material obligations hereunder in whole or in part or in a timely or satisfactory manner, constitutes a breach. The institution of proceedings under any bankruptcy, insolvency, reorganization or similar law, by or against Contractor, or the appointment of a receiver or similar officer for Contractor or any of its property, which is not vacated or fully stayed within twenty (20) days after the institution or occurrence thereof, shall also constitute a breach.

B. Notice and Cure Period

In the event of a breach, the State shall notify the Contractor of such in writing in the manner provided in §16. If such breach is not cured within ten (10) days of receipt of written notice, the State may exercise any of the remedies set forth in §15. Notwithstanding anything to the contrary herein, the State, in its sole discretion, need not provide advance notice or a cure period and may immediately terminate this Contract in whole or in part if reasonably necessary to preserve public safety or to prevent immediate public crisis.

15. REMEDIES

A. Termination for Cause and/or Breach

If Contractor is in breach under any provision of this Contract, the State shall have all of the remedies listed in this §15 in addition to all other remedies set forth in other sections of this Contract, and without limiting its remedies otherwise available at law or equity, following the notice and cure period set forth in §14.B. Remedies are cumulative and the State may exercise any or all of the remedies available to it, in its sole discretion, concurrently or consecutively. The State may terminate this entire Contract or any part of this Contract. Exercise by the State of this right shall not be a breach of its obligations hereunder.

i. Obligations and Rights

To the extent specified in any termination notice, Contractor shall not incur further obligations or render further performance hereunder past the effective date of such notice, and shall terminate outstanding orders and subcontracts with third parties. However, Contractor shall complete and deliver to the State all Work, Services and Goods not cancelled by the termination notice. Contractor shall continue performance of this Contract

up to the effective date of the termination. To the extent the Contract is not terminated, if any, Contractor shall continue performance until the expiration of this Contract. At the sole discretion of the State, Contractor shall assign to the State all of Contractor's right, title, and interest under such terminated orders or subcontracts. Upon termination, Contractor shall take timely, reasonable and necessary action to protect and preserve property in the possession of Contractor in which the State has an interest. All materials owned by the State in the possession of Contractor shall be immediately returned to the State. All Work Product, at the option of the State, shall be delivered by Contractor to the State and shall become the State's property. The Contractor shall be obligated to return any payment advanced under the provisions of this Contract.

ii. Payments

The State shall reimburse Contractor only for accepted performance up to the effective date of the termination. If, after termination by the State, it is determined that Contractor was not in breach or that Contractor's action or inaction was excusable, such termination shall be treated as a termination in the public interest and the rights and obligations of the Parties shall be the same as if this Contract had been terminated in the public interest, as described herein.

iii. Damages and Withholding

Notwithstanding any other remedial action by the State, Contractor shall remain liable to the State for any damages sustained by the State by virtue of any breach under this Contract by Contractor and the State may withhold any payment to Contractor for the purpose of mitigating the State's damages, until such time as the exact amount of damages due to the State from Contractor is determined. The State may withhold any amount that may be due Contractor as the State deems necessary to protect the State against loss, including loss as a result of outstanding liens, claims of former lien holders, or for the excess costs incurred in procuring similar goods or services. Contractor shall be liable for excess costs incurred by the State in procuring from third parties replacement Work, Services or substitute Goods as cover.

B. Early Termination in the Public Interest

The State is entering into this Contract for the purpose of carrying out the public policy of the State of Colorado, as determined by its Governor, General Assembly, and/or courts. If this Contract ceases to further the public policy of the State, the State, in its sole discretion, may terminate this Contract, in whole or in part. Exercise by the State of this right shall not constitute a breach of the State's obligations hereunder. This subsection shall not apply to a termination of this Contract by the State for cause or breach by Contractor, which shall be governed by **§15.A** or as otherwise specifically provided for herein.

i. Method and Content

The State shall notify Contractor of such termination in accordance with §16. The notice shall specify the effective date of the termination, which shall be at least twenty (20) days, and whether it affects all or a portion of this Contract.

ii. Obligations and Rights

Upon receipt of a termination notice, Contractor shall be subject to and comply with the same obligations and rights set forth in §15.A.i.

iii. Payments

If this Contract is terminated by the State pursuant to this §15.B, Contractor shall be paid an amount which bears the same ratio to the total reimbursement under this Contract as Contractor's obligations that were satisfactorily performed bear to the total obligations set forth in this Contract, less payments previously made. Additionally, if this Contract is less than 60% completed upon the effective date of such termination, the State may reimburse Contractor for a portion of actual out-of-pocket expenses (not otherwise reimbursed under this Contract) incurred by Contractor prior to the effective date of the termination in the public interest which are directly attributable to the uncompleted portion of Contractor's obligations hereunder; provided that the sum of any and all reimbursement shall not exceed the maximum amount payable to Contractor hereunder.

C. Additional Remedies

The State, in its sole discretion, may exercise one or more of the following remedies in addition to other remedies available to it:

i. Suspend Performance

Suspend Contractor's performance with respect to all or any portion of this Contract pending necessary corrective action as specified by the State without entitling Contractor to an adjustment in price/cost or performance schedule. Contractor shall promptly cease performance of such portions of the Contract.

ii. Withhold Payment

Withhold payment to Contractor until Contractor's performance or corrections in Contractor's performance are satisfactorily made and completed.

iii. Deny/Reduce Payment

Deny payment for those obligations not performed in conformance with Contract requirements, that due to Contractor's actions or inactions, cannot be performed or, if performed, would be of no value to the State; provided, that any denial or reduction of payment shall be reasonably related to the value to the State of the obligations not performed.

iv. Removal

Notwithstanding any other provision herein, the State may demand immediate removal of any of Contractor's employees, agents, or Subcontractors whom the State deems incompetent, careless, insubordinate, unsuitable, or otherwise unacceptable, or whose continued relation to this Contract is deemed to be contrary to the public interest or the State's best interest.

v. Intellectual Property

If Contractor infringes on a patent, copyright, trademark, trade secret or other intellectual property right while performing its obligations under this Contract, Contractor shall, at the State's option:

- a. Obtain for the State or Contractor the right to use such products and services;
- b. Replace any Goods, Services, or other product involved with non-infringing products or modify them so that they become non-infringing; or,
- c. If neither of the foregoing alternatives are reasonably available, remove any infringing Goods, Services, or products and refund the price paid therefore to the State.

16. NOTICES AND REPRESENTATIVES

Each individual identified below is the principal representative of the designating Party. All notices required to be given hereunder shall be hand delivered with receipt required or sent by certified or registered mail to such Party's principal representative at the address set forth below. In addition to, but not in lieu of, a hard-copy notice, notice also may be sent by e-mail to the e-mail addresses, if any, set forth below. Either Party may from time to time designate by written notice substitute addresses or persons to whom such notices shall be sent. Unless otherwise provided herein, all notices shall be effective upon receipt.

For the State: Hanna Schum, Contract Manager
Department of Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203
Hanna.Schum@State.CO.US

For the Contractor: Patrick Gordon
Rocky Mountain Health Maintenance Organization, Inc.
2775 Crossroads Blvd.
Mesa, CO 81506
patrick.gordon@rmhp.org

17. RIGHTS IN DATA, DOCUMENTS, AND COMPUTER SOFTWARE

Any software, research, reports, studies, data, photographs, negatives or other documents, drawings, models, materials, or Work Product of any type, including drafts, prepared by

Contractor in the performance of its obligations under this Contract shall be the exclusive property of the State, and all Work Product shall be delivered to the State by Contractor upon completion or termination hereof. The State's exclusive rights in such Work Product shall include, but not be limited to, the right to copy, publish, display, transfer, and prepare derivative works. Contractor shall not use, willingly allow, cause or permit such Work Product to be used for any purpose other than the performance of Contractor's obligations hereunder without the prior written consent of the State.

18. GOVERNMENTAL IMMUNITY

Liability for claims for injuries to persons or property arising from the negligence of the State of Colorado, its departments, institutions, agencies, boards, officials, and employees is controlled and limited by the provisions of the Colorado Governmental Immunity Act, CRS §24-10-101, *et seq.*, and the risk management statutes, CRS §24-30-1501, *et seq.*, as now or hereafter amended.

19. GENERAL PROVISIONS

A. Assignment and Subcontracts

Contractor's rights and obligations hereunder are personal and may not be transferred, assigned or subcontracted without the prior, written consent of the State. Any attempt at assignment, transfer or subcontracting without such consent shall be void. All assignments, subcontracts, or Subcontractors approved by the Contractor or the State are subject to all of the provisions hereof. Contractor shall be solely responsible for all of the Work performed under this Contract, regardless of whether Subcontractors are used and for all aspects of subcontracting arrangements and performance. Copies of any and all subcontracts entered into by Contractor to perform its obligations hereunder shall be in writing and submitted to the State upon request. Any and all subcontracts entered into by Contractor related to its performance hereunder shall require the Subcontractor to perform in accordance with the terms and conditions of this Contract and to comply with all applicable federal and state laws. Any and all subcontracts shall include a provision that such subcontracts are governed by the laws of the State of Colorado.

B. Binding Effect

Except as otherwise provided in **§19.A**, all provisions herein contained, including the benefits and burdens, shall extend to and be binding upon the Parties' respective heirs, legal representatives, successors, and assigns.

C. Captions

The captions and headings in this Contract are for convenience of reference only, and shall not be used to interpret, define, or limit its provisions.

D. Counterparts

This Contract may be executed in multiple identical original counterparts, all of which shall constitute one agreement.

E. Entire Understanding

This Contract represents the complete integration of all understandings between the Parties regarding the Work and all prior representations and understandings, oral or written, related to the Work are merged herein. Prior or contemporaneous additions, deletions, or other changes hereto shall not have any force or effect whatsoever, unless embodied herein.

F. Indemnification

Contractor shall indemnify, save, and hold harmless the State, its employees and agents, against any and all claims, damages, liability and court awards including costs, expenses, and attorney fees and related costs, incurred as a result of any act or omission by Contractor, or its employees, agents, Subcontractors, or assignees pursuant to the terms of this Contract; however, the provisions hereof shall not be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protection, or other provisions, of the Colorado Governmental Immunity Act, CRS §24-10-101 *et seq.*, or the Federal Tort Claims Act, 28 U.S.C. 2671 *et seq.*, as applicable, as now or hereafter amended.

G. Jurisdiction and Venue

All suits or actions related to this Contract shall be filed and proceedings held in the State of Colorado and exclusive venue shall be in the City and County of Denver.

H. Modification

i. By the Parties

Except as specifically provided in this Contract, modifications of this Contract shall not be effective unless agreed to in writing by the Parties in an amendment to this Contract, properly executed and approved in accordance with applicable Colorado State law and State Fiscal Rules. Modifications permitted under this Contract, other than contract amendments, shall conform to the policies of the Office of the State Controller, including, but not limited to, the policy entitled MODIFICATIONS OF CONTRACTS - TOOLS AND FORMS.

ii. By Operation of Law

This Contract is subject to such modifications as may be required by changes in Federal or Colorado State law, or their implementing regulations. Any such required modification automatically shall be incorporated into and be part of this Contract on the effective date of such change, as if fully set forth herein.

I. Order of Precedence

The provisions of this Contract shall govern the relationship of the State and Contractor. In the event of conflicts or inconsistencies between this Contract and its exhibits and attachments, including, but not limited to, those provided by

Contractor, such conflicts or inconsistencies shall be resolved by reference to the documents in the following order of priority:

- i. Colorado Special Provisions
- ii. HIPAA Business Associate Addendum
- iii. The provisions of the main body of this Contract
- iv. Exhibit A, Statement of Work
- v. Exhibit B, Covered Services
- vi. Exhibit C, Monthly Payment Rates
- vii. Exhibit D, Flat File Specifications
- viii. Exhibit E, Administrative and Medical Services
- ix. Exhibit F, Covered Behavioral Health Procedure Codes
- x. Exhibit G, Covered Behavioral Health Procedure Codes
- xi. Exhibit H, Encounter Data Specifications
- xii. Exhibit I, Medical Home Model Principles
- xiii. Exhibit J, Serious Reportable or Never Events
- xiv. Exhibit K, Serious Reportable or Never Events
- xv. Exhibit L, Family Planning Documentation Methodology and Reporting
- xvi. Exhibit M, Care Coordination Levels
- xvii. Exhibit N, Disproportionate Share and Graduate Medical Education Hospital Reporting
- xviii. Exhibit O, Medical Loss Ratio (MLR) Calculation Template
- xix. Exhibit P, Sample Option Letter

J. Severability

Provided this Contract can be executed and performance of the obligations of the Parties accomplished within its intent, the provisions hereof are severable and any provision that is declared invalid or becomes inoperable for any reason shall not affect the validity of any other provision hereof.

K. Survival of Certain Contract Terms

Notwithstanding anything herein to the contrary, provisions of this Contract requiring continued performance, compliance, or effect after termination hereof, shall survive such termination and shall be enforceable by the State if Contractor fails to perform or comply as required.

L. Taxes

The State is exempt from all federal excise taxes under IRC Chapter 32 (No. 84-730123K) and from all State and local government sales and use taxes under CRS §§39-26-101 and 201, *et seq.* Such exemptions apply when materials are purchased or services are rendered to benefit the State; provided, however, that certain political subdivisions (e.g., City of Denver) may require payment of sales or use taxes even though the product or service is provided to the State. Contractor shall be solely liable for paying such taxes as the State is prohibited from paying or reimbursing Contractor for such taxes.

M. Third Party Beneficiaries

Enforcement of this Contract and all rights and obligations hereunder are reserved solely to the Parties. Any services or benefits which third parties receive as a result of this Contract are incidental to the Contract, and do not create any rights for such third parties.

N. Waiver

Waiver of any breach under a term, provision, or requirement of this Contract, or any right or remedy hereunder, whether explicitly or by lack of enforcement, shall not be construed or deemed as a waiver of any subsequent breach of such term, provision or requirement, or of any other term, provision, or requirement.

O. CORA Disclosure

To the extent not prohibited by federal law, this Contract and the performance measures and standards under CRS §24-103.5-101, if any, are subject to public release through the Colorado Open Records Act, CRS §24-72-101, et seq.

20. ADDITIONAL GENERAL PROVISIONS

A. Compliance with Applicable Law

The Contractor shall at all times during the execution of this Contract strictly adhere to, and comply with, all applicable federal and state laws, and their implementing regulations, as they currently exist and may hereafter be amended, which are incorporated herein by this reference as terms and conditions of this Contract. The Contractor shall also require compliance with these statutes and regulations in subcontracts and subgrants permitted under this Contract. The federal laws and regulations include:

Age Discrimination Act of 1975, as amended	42 U.S.C. 6101, et seq.
Age Discrimination in Employment Act of 1967	29 U.S.C. 621-634
Americans with Disabilities Act of 1990 (ADA)	42 U.S.C. 12101, et seq.
Clean Air Act	42 U.S.C. 7401, et seq.
Equal Employment Opportunity	E.O. 11246, as amended by E.O. 11375, amending E.O. 11246 and as supplemented by 41 C.F.R. Part 60
Equal Pay Act of 1963	29 U.S.C. 206(d)
Federal Water Pollution Control Act, as amended	33 U.S.C. 1251, et seq.
Immigration Reform and Control Act of 1986	8 U.S.C. 1324b

Section 504 of the Rehabilitation Act of 1973, as amended	29 U.S.C. 794
Title VI of the Civil Rights Act of 1964, as amended	42 U.S.C. 2000d, et seq.
Title VII of the Civil Rights Act of 1964	42 U.S.C. 2000e
Title IX of the Education Amendments of 1972, as amended	20 U.S.C. 1681

State laws include:

Civil Rights Division	Section 24-34-301, CRS, <i>et seq.</i>
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The Contractor also shall comply with any and all laws and regulations prohibiting discrimination in the specific program(s) which is/are the subject of this Contract. In consideration of and for the purpose of obtaining any and all federal and/or state financial assistance, the Contractor makes the following assurances, upon which the State relies.

- i. The Contractor will not discriminate against any person on the basis of race, color, national origin, age, sex, religion or handicap, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related conditions, in performance of Work under this Contract.
- ii. At all times during the performance of this Contract, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in, or denied benefits of the service, programs, or activities performed by the Contractor, or be subjected to any discrimination by the Contractor.

The Contractor shall take all necessary affirmative steps, as required by 45 C.F.R. 92.36(e), Colorado Executive Order and Procurement Rules, to assure that small and minority businesses and women's business enterprises are used, when possible, as sources of supplies, equipment, construction, and services purchased under this Contract.

B. Federal Audit Provisions

Office of Management and Budget (OMB) Circular No. A-133, Audits of States, Local Governments, and Non-Profit Organizations, defines audit requirements under the Single Audit Act of 1996 (Public Law 104-156). All state and local governments and non-profit organizations expending \$500,000.00 or more from all sources (direct or from pass-through entities) are required to comply with the provisions of Circular No. A-133. The Circular also requires pass-through entities to monitor the activities of subrecipients and ensure that subrecipients meet the audit requirements. To identify its pass-through responsibilities, the State of

Colorado requires all subrecipients to notify the State when expected or actual expenditures of federal assistance from all sources equal or exceed \$500,000.00.

C. Debarment and Suspension

- i. If this is a covered transaction or the Contract amount exceeds \$100,000.00, the Contractor certifies to the best of its knowledge and belief that it and its principals and Subcontractors are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency.
- ii. This certification is a material representation of fact upon which reliance was placed when the State determined to enter into this transaction. If it is later determined that the Contractor knowingly rendered an erroneous certification, in addition to other remedies available at law or by contract, the State may terminate this Contract for default.
- iii. The Contractor shall provide immediate written notice to the State if it has been debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded by any Federal department or agency.
- iv. The terms “covered transaction,” “debarment,” “suspension,” “ineligible,” “lower tier covered transaction,” “principal,” and “voluntarily excluded,” as used in this paragraph, have the meanings set out in 2 C.F.R. Parts 180 and 376.
- v. The Contractor agrees that it will include this certification in all lower tier covered transactions and subcontracts that exceed \$100,000.00.

D. Force Majeure

Neither the Contractor nor the State shall be liable to the other for any delay in, or failure of performance of, any covenant or promise contained in this Contract, nor shall any delay or failure constitute default or give rise to any liability for damages if, and only to the extent that, such delay or failure is caused by "force majeure." As used in this Contract, “force majeure” means acts of God; acts of the public enemy; acts of the state and any governmental entity in its sovereign or contractual capacity; fires; floods; epidemics; quarantine restrictions; strikes or other labor disputes; freight embargoes; or unusually severe weather.

E. Disputes

Except as herein specifically provided otherwise, disputes concerning the performance of this Contract which cannot be resolved by the designated Contract representatives shall be referred in writing to a senior departmental management staff designated by the State and a senior manager designated by the Contractor. Failing resolution at that level, disputes shall be presented in writing to the Executive Director of the State and the Contractor’s Chief Executive Officer for resolution. This process is not intended to supersede any other process for the resolution of controversies provided by law.

F. Lobbying

Contractor certifies, to the best of his or her knowledge and belief, that:

- i. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative Contract, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative Contract.
- ii. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an office or employee of any agency, a Member of Congress, an office or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative Contract, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- iii. The undersigned shall require that the language of this certification be included in the award documents for all sub awards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative Contracts) and that all subrecipients shall certify and disclose accordingly.
- iv. This certification is a material representation of fact upon which reliance was placed when the transaction was made or entered into. Submission of the certification is a requisite for making or entering into transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000.00 and not more than \$100,000.00 for each such failure.

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21. COLORADO SPECIAL PROVISIONS

The Special Provisions apply to all contracts except where noted in *italics*.

- A. **CONTROLLER'S APPROVAL. CRS §24-30-202(1).** This contract shall not be valid until it has been approved by the Colorado State Controller or designee.
- B. **FUND AVAILABILITY. CRS §24-30-202(5.5).** Financial obligations of the State payable after the current fiscal year are contingent upon funds for that purpose being appropriated, budgeted, and otherwise made available.
- C. **GOVERNMENTAL IMMUNITY.** No term or condition of this contract shall be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protections, or other provisions, of the Colorado Governmental Immunity Act, CRS §24-10-101 et seq., or the Federal Tort Claims Act, 28 U.S.C. §§1346(b) and 2671 et seq., as applicable now or hereafter amended.
- D. **INDEPENDENT CONTRACTOR.** Contractor shall perform its duties hereunder as an independent contractor and not as an employee. Neither Contractor nor any agent or employee of Contractor shall be deemed to be an agent or employee of the State. Contractor and its employees and agents are not entitled to unemployment insurance or workers compensation benefits through the State and the State shall not pay for or otherwise provide such coverage for Contractor or any of its agents or employees. Unemployment insurance benefits will be available to Contractor and its employees and agents only if such coverage is made available by Contractor or a third party. Contractor shall pay when due all applicable employment taxes and income taxes and local head taxes incurred pursuant to this contract. Contractor shall not have authorization, express or implied, to bind the State to any agreement, liability or understanding, except as expressly set forth herein. Contractor shall (a) provide and keep in force workers' compensation and unemployment compensation insurance in the amounts required by law, (b) provide proof thereof when requested by the State, and (c) be solely responsible for its acts and those of its employees and agents.
- E. **COMPLIANCE WITH LAW.** Contractor shall strictly comply with all applicable federal and State laws, rules, and regulations in effect or hereafter established, including, without limitation, laws applicable to discrimination and unfair employment practices.
- F. **CHOICE OF LAW.** Colorado law, and rules and regulations issued pursuant thereto, shall be applied in the interpretation, execution, and enforcement of this contract. Any provision included or incorporated herein by reference which conflicts with said laws, rules, and regulations shall be null and void. Any provision incorporated herein by reference which purports to negate this or any other Special Provision in whole or in part shall not be valid or enforceable or available in any action at law, whether by way of complaint, defense, or otherwise. Any provision rendered null and void by the operation of this provision shall not invalidate the remainder of this contract, to the extent capable of execution.
- G. **BINDING ARBITRATION PROHIBITED.** The State of Colorado does not agree to binding arbitration by any extra-judicial body or person. Any provision to

the contrary in this contract or incorporated herein by reference shall be null and void.

- H. **SOFTWARE PIRACY PROHIBITION. Governor's Executive Order D 002 00.** State or other public funds payable under this contract shall not be used for the acquisition, operation, or maintenance of computer software in violation of federal copyright laws or applicable licensing restrictions. Contractor hereby certifies and warrants that, during the term of this contract and any extensions, Contractor has and shall maintain in place appropriate systems and controls to prevent such improper use of public funds. If the State determines that Contractor is in violation of this provision, the State may exercise any remedy available at law or in equity or under this contract, including, without limitation, immediate termination of this contract and any remedy consistent with federal copyright laws or applicable licensing restrictions.
- I. **EMPLOYEE FINANCIAL INTEREST/CONFLICT OF INTEREST. CRS §§24-18-201 and 24-50-507.** The signatories aver that to their knowledge, no employee of the State has any personal or beneficial interest whatsoever in the service or property described in this contract. Contractor has no interest and shall not acquire any interest, direct or indirect, that would conflict in any manner or degree with the performance of Contractor's services and Contractor shall not employ any person having such known interests.
- J. **VENDOR OFFSET. CRS §§24-30-202 (1) and 24-30-202.4.** *[Not Applicable to intergovernmental agreements]* Subject to CRS §24-30-202.4 (3.5), the State Controller may withhold payment under the State's vendor offset intercept system for debts owed to State agencies for: (a) unpaid child support debts or child support arrearages; (b) unpaid balances of tax, accrued interest, or other charges specified in CRS §39-21-101, et seq.; (c) unpaid loans due to the Student Loan Division of the Department of Higher Education; (d) amounts required to be paid to the Unemployment Compensation Fund; and (e) other unpaid debts owing to the State as a result of final agency determination or judicial action.
- K. **PUBLIC CONTRACTS FOR SERVICES. CRS §8-17.5-101.** *[Not Applicable to agreements relating to the offer, issuance, or sale of securities, investment advisory services or fund management services, sponsored projects, intergovernmental agreements, or information technology services or products and services]* Contractor certifies, warrants, and agrees that it does not knowingly employ or contract with an illegal alien who will perform work under this contract and will confirm the employment eligibility of all employees who are newly hired for employment in the United States to perform work under this contract, through participation in the E-Verify Program or the Department program established pursuant to CRS §8-17.5-102(5)(c), Contractor shall not knowingly employ or contract with an illegal alien to perform work under this contract or enter into a contract with a subcontractor that fails to certify to Contractor that the subcontractor shall not knowingly employ or contract with an illegal alien to perform work under this contract. Contractor (a) shall not use E-Verify Program or Department program procedures to undertake pre-employment screening of job applicants while this contract is being performed, (b) shall notify the subcontractor and the contracting

State agency within three days if Contractor has actual knowledge that a subcontractor is employing or contracting with an illegal alien for work under this contract, (c) shall terminate the subcontract if a subcontractor does not stop employing or contracting with the illegal alien within three days of receiving the notice, and (d) shall comply with reasonable requests made in the course of an investigation, undertaken pursuant to CRS §8-17.5-102(5), by the Colorado Department of Labor and Employment. If Contractor participates in the Department program, Contractor shall deliver to the contracting State agency, Institution of Higher Education or political subdivision a written, notarized affirmation, affirming that Contractor has examined the legal work status of such employee, and shall comply with all of the other requirements of the Department program. If Contractor fails to comply with any requirement of this provision or CRS §8-17.5-101 et seq., the contracting State agency, institution of higher education or political subdivision may terminate this contract for breach and, if so terminated, Contractor shall be liable for damages.

- L. **PUBLIC CONTRACTS WITH NATURAL PERSONS. CRS §24-76.5-101.** Contractor, if a natural person eighteen (18) years of age or older, hereby swears and affirms under penalty of perjury that he or she (a) is a citizen or otherwise lawfully present in the United States pursuant to federal law, (b) shall comply with the provisions of CRS §24-76.5-101 et seq., and (c) has produced one form of identification required by CRS §24-76.5-103 prior to the effective date of this contract.

SIGNATURE PAGE

THE PARTIES HERETO HAVE EXECUTED THIS CONTRACT

* Persons signing for Contractor hereby swear and affirm that they are authorized to act on Contractor's behalf and acknowledge that the State is relying on their representations to that effect.

CONTRACTOR

Rocky Mountain Health Maintenance
Organization, Inc.

STATE OF COLORADO

John W. Hickenlooper, Governor
Department of Health Care Policy and Financing

*Signature

Susan E. Birch, MBA, BSN, RN
Executive Director

Date: _____

Signatory avers to the State Controller or delegate that Contractor has not begun performance or that a Statutory Violation waiver has been requested under Fiscal Rules

By: _____
Name of Authorized Individual

Date: _____

Title: _____
Official Title of Authorized Individual

LEGAL REVIEW
John W. Suthers, Attorney General

By: _____
Signature - Assistant Attorney General

Date: _____

ALL CONTRACTS REQUIRE APPROVAL BY THE STATE CONTROLLER

CRS §24-30-202 requires the State Controller to approve all State Contracts. This Contract is not valid until signed and dated below by the State Controller or delegate. Contractor is not authorized to begin performance until such time. If Contractor begins performing prior thereto, the State of Colorado is not obligated to pay Contractor for such performance or for any goods and/or services provided hereunder.

STATE CONTROLLER
Robert Jaros, CPA, MBA, JD

By: _____
Department of Health Care Policy and Financing

Date: _____

HIPAA BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum (“Addendum”) is part of the Contract between the State of Colorado, Department of Health Care Policy and Financing and the Contractor. For purposes of this Addendum, the State is referred to as “Department”, “Covered Entity” or “CE” and the Contractor is referred to as “Associate”. Unless the context clearly requires a distinction between the Contract document and this Addendum, all references herein to “the Contract” or “this Contract” include this Addendum.

RECITALS

- A. CE wishes to disclose certain information to Associate pursuant to the terms of the Contract, some of which may constitute Protected Health Information (“PHI”) (defined below).
- B. CE and Associate intend to protect the privacy and provide for the security of PHI disclosed to Associate pursuant to this Contract in compliance with the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §1320d – 1320d-8 (“HIPAA”) as amended by the American Recovery and Reinvestment Act of 2009 (“ARRA”)/HITECH Act (P.L. 111-005), and its implementing regulations promulgated by the U.S. Department of Health and Human Services, 45 C.F.R. Parts 160, 162 and 164 (the “HIPAA Rules”) and other applicable laws, as amended.
- C. As part of the HIPAA Rules, the CE is required to enter into a contract containing specific requirements with Associate prior to the disclosure of PHI, as set forth in, but not limited to, Title 45, Sections 160.103, 164.502(e) and 164.504(e) of the Code of Federal Regulations (“C.F.R.”) and contained in this Addendum.

The parties agree as follows:

1. Definitions.

a. Except as otherwise defined herein, capitalized terms in this Addendum shall have the definitions set forth in the HIPAA Rules at 45 C.F.R. Parts 160, 162 and 164, as amended. In the event of any conflict between the mandatory provisions of the HIPAA Rules and the provisions of this Contract, the HIPAA Rules shall control. Where the provisions of this Contract differ from those mandated by the HIPAA Rules, but are nonetheless permitted by the HIPAA Rules, the provisions of this Contract shall control.

b. “Protected Health Information” or “PHI” means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the HIPAA Rules, including, but not limited to, 45 C.F.R. Section 164.501.

c. “Protected Information” shall mean PHI provided by CE to Associate or created, received, maintained or transmitted by Associate on CE’s behalf. To the extent Associate is a covered entity under HIPAA and creates or obtains its own PHI for treatment, payment and health care operations, Protected Information under this Contract does not include any PHI created or obtained by Associate as a covered entity and Associate shall follow its own policies and procedures for accounting, access and amendment of Associate’s PHI.

d. “Subcontractor” shall mean a third party to whom Associate delegates a function, activity, or service that involves CE’s Protected Information, in order to carry out the responsibilities of this Agreement.

2. Obligations of Associate.

a. Permitted Uses. Associate shall not use Protected Information except for the purpose of performing Associate’s obligations under this Contract and as permitted under this Addendum. Further, Associate shall not use Protected Information in any manner that would constitute a violation of the HIPAA Rules if so used by CE, except that Associate may use Protected Information: (i) for the proper management and administration of Associate; (ii) to carry out the legal responsibilities of Associate; or (iii) for Data Aggregation purposes for the Health Care Operations of CE. Additional provisions, if any, governing permitted uses of Protected Information are set forth in Attachment A to this Addendum. Associate agrees to defend and indemnify the Department against third party claims arising from Associate’s breach of this Addendum.

b. Permitted Disclosures. Associate shall not disclose Protected Information in any manner that would constitute a violation of the HIPAA Rules if disclosed by CE, except that Associate may disclose Protected Information: (i) in a manner permitted pursuant to this Contract; (ii) for the proper management and administration of Associate; (iii) as required by law; (iv) for Data Aggregation purposes for the Health Care Operations of CE; or (v) to report violations of law to appropriate federal or state authorities, consistent with 45 C.F.R. Section 164.502(j)(1). To the extent that Associate discloses Protected Information to a third party Subcontractor, Associate must obtain, prior to making any such disclosure: (i) reasonable assurances through execution of a written agreement with such third party that such Protected Information will be held confidential as provided pursuant to this Addendum and only disclosed as required by law or for the purposes for which it was disclosed to such third party; and that such third party will notify Associate within five (5) business days of any breaches of confidentiality of the Protected Information, to the extent it has obtained knowledge of such breach. Additional provisions, if any, governing permitted disclosures of Protected Information are set forth in Attachment A.

c. Appropriate Safeguards. Associate shall implement appropriate safeguards as are necessary to prevent the use or disclosure of Protected Information other than as permitted by this Contract. Associate shall comply with the requirements of the HIPAA Security Rule, at 45 C.F.R. Sections 164.308, 164.310, 164.312, and 164.316. Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Associate’s operations and the nature and scope of its activities. Associate shall review, modify, and update documentation of its

safeguards as needed to ensure continued provision of reasonable and appropriate protection of Protected Information.

d. Reporting of Improper Use or Disclosure. Associate shall report to CE in writing any use or disclosure of Protected Information other than as provided for by this Contract within five (5) business days of becoming aware of such use or disclosure.

e. Associate's Agents. If Associate uses one or more Subcontractors or agents to provide services under the Contract, and such Subcontractors or agents receive or have access to Protected Information, each Subcontractor or agent shall sign an agreement with Associate containing substantially the same provisions as this Addendum and further identifying CE as a third party beneficiary with rights of enforcement and indemnification from such Subcontractors or agents in the event of any violation of such Subcontractor or agent agreement. The agreement between the Associate and Subcontractor or agent shall ensure that the Subcontractor or agent agrees to at least the same restrictions and conditions that apply to Associate with respect to such Protected Information. Associate shall implement and maintain sanctions against agents and Subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation.

f. Access to Protected Information. If Associate maintains Protected Information contained within CE's Designated Record Set, Associate shall make Protected Information maintained by Associate or its agents or Subcontractors in such Designated Record Sets available to CE for inspection and copying within ten (10) business days of a request by CE to enable CE to fulfill its obligations to permit individual access to PHI under the HIPAA Rules, including, but not limited to, 45 C.F.R. Section 164.524. If such Protected Information is maintained by Associate in an electronic form or format, Associate must make such Protected Information available to CE in a mutually agreed upon electronic form or format.

g. Amendment of PHI. If Associate maintains Protected Information contained within CE's Designated Record Set, Associate or its agents or Subcontractors shall make such Protected Information available to CE for amendment within ten (10) business days of receipt of a request from CE for an amendment of Protected Information or a record about an individual contained in a Designated Record Set, and shall incorporate any such amendment to enable CE to fulfill its obligations with respect to requests by individuals to amend their PHI under the HIPAA Rules, including, but not limited to, 45 C.F.R. Section 164.526. If any individual requests an amendment of Protected Information directly from Associate or its agents or Subcontractors, Associate must notify CE in writing within five (5) business days of receipt of the request. Any denial of amendment of Protected Information maintained by Associate or its agents or Subcontractors shall be the responsibility of CE.

h. Accounting Rights. Associate and its agents or Subcontractors shall make available to CE, within ten (10) business days of notice by CE, the information required to provide an accounting of disclosures to enable CE to fulfill its obligations under the HIPAA Rules, including, but not limited to, 45 C.F.R. Section 164.528. In the event that the request for an accounting is delivered directly to Associate or its agents or Subcontractors, Associate shall within five (5) business days of the receipt of the request, forward it to CE in writing. It shall be CE's

responsibility to prepare and deliver any such accounting requested. Associate shall not disclose any Protected Information except as set forth in Section 2(b) of this Addendum.

i. Governmental Access to Records. Associate shall keep records and make its internal practices, books and records relating to the use and disclosure of Protected Information available to the Secretary of the U.S. Department of Health and Human Services (the "Secretary"), in a time and manner designated by the Secretary, for purposes of determining CE's or Associate's compliance with the HIPAA Rules. Associate shall provide to CE a copy of any Protected Information that Associate provides to the Secretary concurrently with providing such Protected Information to the Secretary when the Secretary is investigating CE. Associate shall cooperate with the Secretary if the Secretary undertakes an investigation or compliance review of Associate's policies, procedures or practices to determine whether Associate is complying with the HIPAA Rules, and permit access by the Secretary during normal business hours to its facilities, books, records, accounts, and other sources of information, including Protected Information, that are pertinent to ascertaining compliance.

j. Minimum Necessary. Associate (and its agents or Subcontractors) shall only request, use and disclose the minimum amount of Protected Information necessary to accomplish the purpose of the request, use or disclosure, in accordance with the Minimum Necessary requirements of the HIPAA Rules including, but not limited to, 45 C.F.R. Sections 164.502(b) and 164.514(d).

k. Data Ownership. Associate acknowledges that Associate has no ownership rights with respect to the Protected Information.

l. Retention of Protected Information. Except upon termination of the Contract as provided in Section 4(c) of this Addendum, Associate and its Subcontractors or agents shall retain all Protected Information throughout the term of this Contract and shall continue to maintain the information required under Section 2(h) of this Addendum for a period of six (6) years.

m. Associate's Insurance. Associate shall maintain insurance to cover loss of PHI data and claims based upon alleged violations of privacy rights through improper use or disclosure of PHI. All such policies shall meet or exceed the minimum insurance requirements of the Contract (e.g., occurrence basis, combined single dollar limits, annual aggregate dollar limits, additional insured status and notice of cancellation).

n. Notification of Breach. During the term of this Contract, Associate shall notify CE within five (5) business days of any suspected or actual breach of security, intrusion or unauthorized use or disclosure of Protected Information and/or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws or regulations. Associate shall not initiate notification to affected individuals per the HIPAA Rules without prior notification and approval of CE. Information provided to CE shall include the identification of each individual whose unsecured PHI has been, or is reasonably believed to have been accessed, acquired or disclosed during the breach. Associate shall take (i) prompt corrective action to cure any such deficiencies and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.

o. Audits, Inspection and Enforcement. Within ten (10) business days of a written request by CE, Associate and its agents or Subcontractors shall allow CE to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the use or disclosure of Protected Information pursuant to this Addendum for the purpose of determining whether Associate has complied with this Addendum; provided, however, that: (i) Associate and CE shall mutually agree in advance upon the scope, timing and location of such an inspection; and (ii) CE shall protect the confidentiality of all confidential and proprietary information of Associate to which CE has access during the course of such inspection. The fact that CE inspects, or fails to inspect, or has the right to inspect, Associate's facilities, systems, books, records, agreements, policies and procedures does not relieve Associate of its responsibility to comply with this Addendum, nor does CE's (i) failure to detect or (ii) detection, but failure to notify Associate or require Associate's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of CE's enforcement rights under the Contract.

p. Safeguards During Transmission. Associate shall be responsible for using appropriate safeguards, including encryption of PHI, to maintain and ensure the confidentiality, integrity and security of Protected Information transmitted to CE pursuant to the Contract, in accordance with the standards and requirements of the HIPAA Rules.

q. Restrictions and Confidential Communications. Within ten (10) business days of notice by CE of a restriction upon uses or disclosures or request for confidential communications pursuant to 45 C.F.R. Section 164.522, Associate will restrict the use or disclosure of an individual's Protected Information. Associate will not respond directly to an individual's requests to restrict the use or disclosure of Protected Information or to send all communication of Protected Information to an alternate address. Associate will refer such requests to the CE so that the CE can coordinate and prepare a timely response to the requesting individual and provide direction to Associate.

3. Obligations of CE.

a. Safeguards During Transmission. CE shall be responsible for using appropriate safeguards, including encryption of PHI, to maintain and ensure the confidentiality, integrity and security of Protected Information transmitted pursuant to this Contract, in accordance with the standards and requirements of the HIPAA Rules.

b. Notice of Changes. CE maintains a copy of its Notice of Privacy Practices on its website. CE shall provide Associate with any changes in, or revocation of, permission to use or disclose Protected Information, to the extent that it may affect Associate's permitted or required uses or disclosures. To the extent that it may affect Associate's permitted use or disclosure of PHI, CE shall notify Associate of any restriction on the use or disclosure of Protected Information that CE has agreed to in accordance with 45 C.F.R. Section 164.522.

4. Termination.

a. Material Breach. In addition to any other provisions in the Contract regarding breach, a breach by Associate of any provision of this Addendum, as determined by CE, shall

constitute a material breach of this Contract and shall provide grounds for immediate termination of this Contract by CE pursuant to the provisions of the Contract covering termination for cause, if any. If the Contract contains no express provisions regarding termination for cause, the following terms and conditions shall apply:

(1) Default. If Associate refuses or fails to timely perform any of the provisions of this Contract, CE may notify Associate in writing of the non-performance, and if not promptly corrected within the time specified, CE may terminate this Contract. Associate shall continue performance of this Contract to the extent it is not terminated and shall be liable for excess costs incurred in procuring similar goods or services elsewhere.

(2) Associate's Duties. Notwithstanding termination of this Contract, and subject to any directions from CE, Associate shall take timely, reasonable and necessary action to protect and preserve property in the possession of Associate in which CE has an interest.

b. Reasonable Steps to Cure Breach. If CE knows of a pattern of activity or practice of Associate that constitutes a material breach or violation of the Associate's obligations under the provisions of this Addendum or another arrangement, then CE shall take reasonable steps to cure such breach or end such violation. If CE's efforts to cure such breach or end such violation are unsuccessful, CE shall terminate the Contract, if feasible. If Associate knows of a pattern of activity or practice of a Subcontractor or agent that constitutes a material breach or violation of the Subcontractor's or agent's obligations under the written agreement between Associate and the Subcontractor or agent, Associate shall take reasonable steps to cure such breach or end such violation, if feasible.

c. Effect of Termination.

(1) Except as provided in paragraph (2) of this subsection, upon termination of this Contract, for any reason, Associate shall return or destroy all Protected Information that Associate or its agents or Subcontractors still maintain in any form, and shall retain no copies of such Protected Information. If Associate elects to destroy the Protected Information, Associate shall certify in writing to CE that such Protected Information has been destroyed.

(2) If Associate believes that returning or destroying the Protected Information is not feasible, Associate shall promptly provide CE notice of the conditions making return or destruction infeasible. Associate shall continue to extend the protections of Sections 2(a), 2(b), 2(c), 2(d) and 2(e) of this Addendum to such Protected Information, and shall limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible.

5. Injunctive Relief. CE shall have the right to injunctive and other equitable and legal relief against Associate or any of its Subcontractors or agents in the event of any use or disclosure of Protected Information in violation of this Contract or applicable law.

6. No Waiver of Immunity. No term or condition of this Contract shall be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protection, or other provisions of the Colorado Governmental Immunity Act, CRS 24-10-101 *et seq.* or the

Federal Tort Claims Act, 28 U.S.C. 2671 *et seq.* as applicable, as now in effect or hereafter amended.

7. Limitation of Liability. Any limitation of Associate's liability in the Contract shall be inapplicable to the terms and conditions of this Addendum.

8. Disclaimer. CE makes no warranty or representation that compliance by Associate with this Contract or the HIPAA Rules will be adequate or satisfactory for Associate's own purposes. Associate is solely responsible for all decisions made by Associate regarding the safeguarding of PHI.

9. Certification. To the extent that CE determines an examination is necessary in order to comply with CE's legal obligations pursuant to the HIPAA Rules relating to certification of its security practices, CE or its authorized agents or contractors, may, at CE's expense, examine Associate's facilities, systems, procedures and records as may be necessary for such agents or contractors to certify to CE the extent to which Associate's security safeguards comply with the HIPAA Rules or this Addendum.

10. Amendment.

a. Amendment to Comply with Law. The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of the HIPAA Rules and other applicable laws relating to the confidentiality, integrity, availability and security of PHI. The parties understand and agree that CE must receive satisfactory written assurance from Associate that Associate will adequately safeguard all Protected Information and that it is Associate's responsibility to receive satisfactory written assurances from Associate's Subcontractors and agents. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Addendum embodying written assurances consistent with the standards and requirements of the HIPAA Rules or other applicable laws. CE may terminate this Contract upon thirty (30) days written notice in the event (i) Associate does not promptly enter into negotiations to amend this Contract when requested by CE pursuant to this Section, or (ii) Associate does not enter into an amendment to this Contract providing assurances regarding the safeguarding of PHI that CE, in its sole discretion, deems sufficient to satisfy the standards and requirements of the HIPAA Rules.

b. Amendment of Attachment A. Attachment A may be modified or amended by mutual agreement of the parties in writing from time to time without formal amendment of this Addendum.

11. Assistance in Litigation or Administrative Proceedings. Associate shall make itself, and any Subcontractors, employees or agents assisting Associate in the performance of its obligations under the Contract, available to CE, at no cost to CE, up to a maximum of thirty (30) hours, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being

commenced against CE, its directors, officers or employees based upon a claimed violation of the HIPAA Rules or other laws relating to security and privacy or PHI, in which the actions of Associate are at issue, except where Associate or its Subcontractor, employee or agent is a named adverse party.

12. No Third Party Beneficiaries. Nothing express or implied in this Contract is intended to confer, nor shall anything herein confer, upon any person other than CE, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

13. Interpretation and Order of Precedence. The provisions of this Addendum shall prevail over any provisions in the Contract that may conflict or appear inconsistent with any provision in this Addendum. Together, the Contract and this Addendum shall be interpreted as broadly as necessary to implement and comply with the HIPAA Rules. The parties agree that any ambiguity in this Contract shall be resolved in favor of a meaning that complies and is consistent with the HIPAA Rules. This Contract supersedes and replaces any previous separately executed HIPAA addendum between the parties.

14. Survival of Certain Contract Terms. Notwithstanding anything herein to the contrary, Associate's obligations under Section 4(c) ("Effect of Termination") and Section 12 ("No Third Party Beneficiaries") shall survive termination of this Contract and shall be enforceable by CE as provided herein in the event of such failure to perform or comply by the Associate. This Addendum shall remain in effect during the term of the Contract including any extensions.

ATTACHMENT A

This Attachment sets forth additional terms to the HIPAA Business Associate Addendum, which is part of the Contract between the State of Colorado, Department of Health Care Policy and Financing and the Contractor and is effective as of the date of the Contract (the “Attachment Effective Date”). This Attachment may be amended from time to time as provided in Section 10(b) of the Addendum.

1. Additional Permitted Uses. In addition to those purposes set forth in Section 2(a) of the Addendum, Associate may use Protected Information as follows:

No Additional Permitted Uses.

2. Additional Permitted Disclosures. In addition to those purposes set forth in Section 2(b) of the Addendum, Associate may disclose Protected Information as follows:

No additional permitted disclosures.

3. **Subcontractor(s). The parties acknowledge that the following subcontractors or agents of Associate shall receive Protected Information in the course of assisting Associate in the performance of its obligations under this Contract:**

No Subcontractors.

4. Receipt. Associate’s receipt of Protected Information pursuant to this Contract shall be deemed to occur as follows and Associate’s obligations under the Addendum shall commence with respect to such Protected Information upon such receipt:

Upon receipt of PHI from the Department.

5. Additional Restrictions on Use of Data. CE is a Business Associate of certain other Covered Entities and, pursuant to such obligations of CE, Associate shall comply with the following restrictions on the use and disclosure of Protected Information:

No additional restrictions on Use of Data.

6. **Additional Terms. This may include specifications for disclosure format, method of transmission, use of an intermediary, use of digital signatures or PKI, authentication, additional security or privacy specifications, de-identification/re-identification of data, etc.**

No additional terms.

EXHIBIT A
STATEMENT OF WORK

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SECTION 1.0 TERMINOLOGY

1.1. ADDITIONAL ACRONYMS, ABBREVIATIONS AND DEFINITIONS

- 1.1.1. Acronyms and abbreviations are defined at their first occurrence in this Statement of Work. The following list of acronyms, abbreviations and definitions is provided to assist the reader in understanding terminology used throughout this document.
 - 1.1.1.1. “Accountable Care Collaborative” or “ACC” is the primary Medicaid program designed to improve Members' health and reduce costs. Medicaid Members in the ACC will receive the regular Medicaid benefit package, and will also belong to a Regional Care Collaborative Organization (RCCO). This contract is a pilot program within the ACC.
 - 1.1.1.2. “Advance Directive” means a written instrument recognized under Section 15-14-505(2), C.R.S., and defined in 42 CFR 489.100, relating to the provision of medical care when the individual is incapacitated.
 - 1.1.1.3. “Alternative Benefit Plan” or “ABP” means the benefit plan that Expansion Members will receive pursuant to Section 1937 of the Social Security Act. The ABP is the regular Medicaid benefit package plus Habilitative therapies.
 - 1.1.1.4. “CAHPS” means the Consumer Assessment of Healthcare Providers and Systems Health Plan Surveys.
 - 1.1.1.5. “Care Coordination” means the process of identifying, screening and assessing Members’ needs (medical and nonmedical), identification of and referral to appropriate services, and coordinating and monitoring an individualized care plan. This treatment plan shall also include a strategy to ensure that all Members and/or authorized family members or guardians are involved in treatment planning and consent to the medical treatment.
 - 1.1.1.6. “Client” means an individual eligible for and enrolled in the Colorado Medicaid Program.
 - 1.1.1.7. “CMS” means the federal Centers for Medicare and Medicaid Services.
 - 1.1.1.8. “Cold-Call Marketing” means any unsolicited personal contact by the MCO with a Potential Member for the purposes of marketing as defined at 42 CFR 438.104.
 - 1.1.1.9. “Communication Disability” means an expressive or receptive impairment that creates a barrier to communication between a Member and a person not familiar with that Member.
 - 1.1.1.10. “Contractor’s Plan” means the Contractor’s network or those Covered Services provided by the Contractor to eligible Clients in accordance with the terms and conditions of this agreement.

- 1.1.1.11. “Covered Drugs” means those drugs currently covered by the Medicaid program and includes those products that require prior authorization by the Colorado Medicaid program. Covered Drugs must be dispensed by a Participating Provider except for Emergency Services and must be prescribed by Participating Providers or requested by an authorized prescriber as a result of authorized Referral, Emergency Services, dental care, or obtained under the Medicaid Mental Health Capitation Program. Covered Drugs shall also mean drugs for which payments are made by the Contractor as a result of Appeal and External Review Processes.
- 1.1.1.12. “Covered Services” means those services described in Exhibit B, Covered Services, attached hereto and made part of this Contract, which the Contractor is required to provide or arrange to be provided to a Member. Covered Services shall also mean services for which payments are made by the Contractor as a result of Appeal and External Review Processes.
- 1.1.1.13. “Day(s)” means calendar days, unless otherwise specified.
- 1.1.1.14. “Desk Audit” means the review of materials submitted upon request to the Department or its agents for quality assurance activities.
- 1.1.1.15. “Designated Client Representative” means any person, including a treating health care professional, authorized in writing by the Member or the Member's legal guardian to represent his or her interests related to complaints or appeals about health care benefits and services as defined at 10 C.C.R. 2505-10, Section 8.209.2.
- 1.1.1.16. “Disability” or “Disabilities” means, with respect to a Member, a physical or mental impairment that substantially limits one or more of the major life activities of such Member, in accordance with the Americans with Disabilities Act of 1990, 42 U.S.C. Section 12101, *et seq.*
- 1.1.1.17. “Disenrollment” or “Disenroll” means the act of discontinuing a Member’s Enrollment in the Contractor’s Plan.
- 1.1.1.18. “DRAMS” means the Department’s Drug Rebate Analysis Management System.
- 1.1.1.19. “Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could responsibly expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman or her unborn child) in serious jeopardy, serious impairments to bodily functions, or serious dysfunction of any bodily organ or part.
- 1.1.1.20. “Emergency Services” means covered inpatient and outpatient services that are: furnished by a provider that is qualified to furnish these services under this 42 CFR 438.114 (a) and that are needed to evaluate or stabilize an emergency medical condition.
- 1.1.1.21. “Encounter Claims Data” means claims data resulting from an occurrence of examination or treatment of a member by a medical practitioner or in a medical facility and includes pharmacy prescriptions. Mental health care is also included if provided under the auspices of this Contract.

- 1.1.1.22. “Enroll” or “Enrollment” means the act of entering a Client as a Member of the Contractor’s Plan.
- 1.1.1.23. “Enrolled” means a Client who is a Member of the Contractor’s Plan.
- 1.1.1.24. “Enrollee” means Member.
- 1.1.1.25. “EPSDT” means the Early, Periodic, Screening, Diagnosis and Treatment program that provides comprehensive health care to all Medicaid eligible children through periodic screenings, diagnostic and treatment services as defined at 10 CCR 2505-10, Section 8.280.1.
- 1.1.1.26. “Expansion Clients” means an individual eligible for and enrolled in the Colorado Medicaid Program, specifically childless adults 0-133% FPL and parents and caretaker relatives 69-133% FPL.
- 1.1.1.27. “Expansion Members” means any Expansion Client who is Enrolled in the Contractor's Plan. Any Expansion Client in the Contractor’s service area is a potential Expansion Member.
- 1.1.1.28. “FDA” means the federal Food and Drug Administration.
- 1.1.1.29. “Federally Qualified Health Center” or “FQHC”, means a hospital-based or free standing center that meets the FQHC definition found in Section 1905(1)(2)(B) of the Social Security Act. Section 1905(1)(2)(B).
- 1.1.1.30. “Federal Poverty Level” or “FPL” means the set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. It is determined by the Department of Health and Human Services on an annual basis. Medicaid uses FPL to define eligibility income limits.
- 1.1.1.31. “Financial Reconciliation” means a reconciliation, as described in section 5.5 of this Statement of Work, necessary to comply with 42 C.F.R. 447.362.
- 1.1.1.32. “FQHC Encounter Rate” means the rate established by the Department to reimburse Federally Qualified Health Centers.
- 1.1.1.33. “Grievance” means an oral or written expression of dissatisfaction about any matter other than an action, including but not limited to quality of care or services provided and aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the member’s rights as defined at 10 CCR 2505-10, Section 8.209.1.
- 1.1.1.34. “Habilitative Services” means services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in the regular Medicaid benefit package. Parity in this context means of like type and substantially equivalent in scope, amount, and duration.
- 1.1.1.35. “HEDIS” means the Healthcare Effectiveness Data and Information Set developed and maintained by the National Committee for Quality Assurance.
- 1.1.1.36. “Home Health Services” means those services described at 10 C.C.R 2505-10, Section 8.520.

- 1.1.1.37. “Hospital Services” means those Medically Necessary Covered Services for members that are generally and customarily provided by acute care general Hospitals. Hospital Services shall also include services rendered in the emergency room and/or the outpatient department of any Hospital. Except for a Medical Emergency or Written Referral, Hospital Services are Covered Services only when performed by Participating Providers.
- 1.1.1.38. “Hospital” means an institution which:
- 1.1.1.38.1. Is licensed by the State as a Hospital;
 - 1.1.1.38.2. Has a Utilization Review program that meets Medicare conditions of participation;
 - 1.1.1.38.3. Is primarily engaged in providing medical care and treatment for sick and injured persons on an inpatient basis through medical, diagnostic and major surgical facilities, under the supervision of a staff of Physicians and with twenty-four-hour-a-day nursing service; and
 - 1.1.1.38.4. Is certified by Medicare or, in the case of a specialty care center not eligible for Medicare certification, meets criteria established or recognized by the Department in accordance with any applicable state and federal statute or regulation.
- 1.1.1.39. “Independent Living” means the ability of a Member with a Disability to function at home, work and in the community-at-large to the greatest extent possible and in the least restrictive manner.
- 1.1.1.40. “Key Personnel” means the individual filling the position of the Contract Manager, Financial Manager, and Medical Director.
- 1.1.1.41. “Marketing” or “Marketing Activities” means any communication, from an MCO, to a Medicaid beneficiary who is not enrolled in the Contractor’s Plan, that can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular MCO’s Medicaid product, or either to not enroll in, or to disenroll from, another MCO’s, Medicaid product as defined at 42 CFR 438.104.
- 1.1.1.42. “Marketing Materials” means materials that are produced in any medium by or on behalf of the Contractor and can be reasonably interpreted as intended to market to potential Members.
- 1.1.1.43. “Medical Home” means an approach to providing comprehensive primary-care that facilitates partnerships between individual members, their providers, and, where appropriate, the member’s family, that meets the requirements described in Exhibit I, Medical Home Model Principles.
- 1.1.1.44. “Medical Loss Ratio” (MLR) means the amount the Medical Spend divided by total capitation payments made to the Contractor annually.

- 1.1.1.45. “Medical Management” means activities related to ensuring clients receive necessary medical services. This may include traditional activities, such as integrating disease management into the care of members with multiple chronic illnesses, and non-traditional methods, such as using technology enhanced communication (e.g. texts) or delivering care in alternative formats (e.g. group visits).
- 1.1.1.46. “Medically Necessary” is defined in Exhibit B.
- 1.1.1.47. “Medical Record” means the collection of personal information, which relates an individual's physical or mental condition, medical history, or medical treatment, that is obtained from a single health care Provider, medical care institution, Member of the Contractor's Plan, or the spouse, parent or legal guardian of a Member.
- 1.1.1.48. “Medical Screening Examination” means screening of sick, wounded or injured persons in the emergency room to determine whether the person has an Emergency Medical Condition.
- 1.1.1.49. “Medical Spend” means the sum of the direct, indirect, and sub-contracted costs for providing all Covered Services provided under this Contract, verified through encounters submitted through the Medicaid Management Information System and supplemental financial information, subject to Department approval.
- 1.1.1.50. “Member” means any Client who is Enrolled in the Contractor's Plan.
- 1.1.1.51. “Modified Adjusted Gross Income” or “MAGI” refers to the methodology by which income and household composition are determined for the MAGI Medical Assistance groups under the Affordable Care Act.
- 1.1.1.52. “Non-emergency” or “Non-emergent” means non-acute or chronic medical condition, wellness maintenance and/or prescription refills that require medical intervention, when the Member’s condition is stable.
- 1.1.1.53. “Nursing Facility” means an institution that can meet state and federal requirements for participation as a Nursing Facility.
- 1.1.1.54. “Open Enrollment Period” means the two (2) months immediately preceding the month in which a Member’s birthday occurs.
- 1.1.1.55. “Participating Provider” means a Provider who is in the employ of, or who has entered into an agreement with, the Contractor to provide medical services to the Contractor’s Members. Primary care providers who are “Participating Providers” are referred to as “Primary Care Medical Providers.”
- 1.1.1.56. “Persons with Special Health Care Needs” or “Special Health Care Needs” means persons as defined in 10 C.C.R. 2505-10, §8.205.9, *et seq.*
- 1.1.1.57. “Physician” means any doctor licensed to practice medicine or osteopathy in the State of Colorado or in the state in which such medical care is rendered.
- 1.1.1.58. “Post Stabilization Services” means covered services, related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the Member's condition.

- 1.1.1.59. “Potential Enrollee” means “Potential Member.”
- 1.1.1.60. “Potential Member” means a Medicaid recipient who is subject to passive enrollment or may voluntarily elect to enroll in the Contractor’s Plan, but is not yet an enrollee.
- 1.1.1.61. “Primary Care Medical Provider” or “PCMP” means a primary care provider who serves as a Medical Home for Members in the ACC. A PCMP may be a FQHC, RHC, clinic or other group practice that provides the majority of the Member’s comprehensive primary, preventative and sick care. A PCMP may also be an individual or pods of PCMPs that are physicians, advanced practice nurses or physicians assistants with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics or obstetrics and gynecology.
- 1.1.1.62. “Provider” means a health care practitioner, institution, agency or supplier, which may or may not be a Participating Provider in the Contractor’s Plan, but which furnishes or arranges for health care services with an expectation of receiving payment.
- 1.1.1.63. “Proprietary Information” means information relating to a Contractor’s research, development, trade secrets, business affairs, internal operations and management procedures. It includes those of its customers, Members or affiliates, but does not include information lawfully obtained from third parties or that which is in the public domain.
- 1.1.1.64. “Psychiatric In Nature” means those occasions of service in which the Member has a diagnosis listed in Exhibit F, Covered Behavioral Health Procedure Codes, attached and incorporated herein by reference, and receives services listed in Exhibit F for the listed diagnosis.
- 1.1.1.65. “Qualified Interpreter” means an interpreter who is able to interpret effectively, accurately and impartially, both receptively and expressively, using any necessary specialized vocabulary.
- 1.1.1.66. “RCCO” means Regional Care Collaborative Organization.
- 1.1.1.67. “Referral” or “Written Referral” means any form of written communication or other permanent record by the Contractor and/or authorized Participating Provider that authorizes a Member to seek care from a Provider other than a Participating Provider.
- 1.1.1.68. “Serious Reportable Events” or “Never Events” means hospital acquired conditions that were not present on admission (POA) as an inpatient and that alter the condition or diagnosis of the individual receiving care.
- 1.1.1.69. “Service Area” means that area for which the Department and the Contractor have agreed that the Contractor will provide Covered Services to Members. The Service Area shall be the counties of Mesa, Montrose, Delta, Gunnison, Pitkin, Garfield, and Rio Blanco.
- 1.1.1.70. “Service Authorization” means the request by a Member for a Medically Necessary, Covered Service.

- 1.1.1.71. “Site Review” means the visit of Department staff or its designees to the site or the administrative office(s) of a Participating Provider and/or the Contractor and its Participating Providers.
- 1.1.1.72. “Subcontractor” means an individual or entity performing all or part of the services covered by this Contract, under a separate contract with the Contractor. The terms Subcontractor and Subcontractors mean Subcontractor(s) in any tier.
- 1.1.1.73. “Triage” means the assessment of a Member’s condition and direction of the Member to the most appropriate setting for Medically Necessary care.
- 1.1.1.74. “Urgently Needed Services” means Covered Services as defined at 42 C.F.R. §422.113(b)(1)(iii).
- 1.1.1.75. “Utilization Management” means the function wherein use, consumption and outcomes of services, along with level and intensity of care, are reviewed using Utilization Review techniques for their appropriateness.
- 1.1.1.76. “Utilization Review” means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, Referrals, procedures or settings.
- 1.1.1.77. “Work” means the tasks and activities Contractor is required to perform to fulfill its obligations under this Contract, including the performance of any services and delivery of any goods.
- 1.1.1.78. “Wrap Around Benefits” means those Medicaid services which either exceed coverage limitations the Contractor is required by this Contract to provide or, the Contractor is not obligated to provide coverage for under this Contract. Wrap Around Benefits are services reimbursable under the Medicaid fee-for-service and must be billed directly to the Department's fiscal agent by the Provider. Wrap Around Benefits include, but are not limited to, EPSDT Extraordinary Home Health Services, medical transportation, and private duty nursing.

SECTION 2.0 BACKGROUND

2.1. GENERAL PROGRAM BACKGROUND

- 2.1.1. House Bill 12-1281 of the Second Regular Session of the 68th General Assembly was passed in 2012, creating Section 25.5-5-415 of the Colorado Revised Statutes (C.R.S.), which allowed the Department of Health Care Policy and Financing (Department) to accept proposals for an innovative payment reform pilot that demonstrates new ways of paying for improved client outcomes while reducing costs in the Accountable Care Collaborative (ACC) program. The Department solicited proposals from the seven ACC Regional Care Collaborative Organizations (RCCOs) in the state. Rocky Mountain Health Plans' proposal was selected by the Department.
- 2.1.2. This managed care Contract is the result of C.R.S. 25.5-5-415 and operates within the ACC program. As the ACC program evolves, the Department intends to align this Contract with the program as a whole.

SECTION 3.0 CONTRACTOR AND SERVICE REQUIREMENTS

3.1. GENERAL CONTRACTOR REQUIREMENTS

- 3.1.1. Where policies, procedures, programs and plans are required by this Contract or Department regulations, the Contractor shall maintain and provide internal documents that clearly demonstrate all such requirements and the responsibilities of the Contractor. Where the Contractor is required to communicate to Providers, documentation may exist outside of the Contractor's internal policies and procedures, generally in the form of direct Provider correspondence or a Provider manual. Exception can be made for a single source for Provider and Contractor documents if the Contractor clearly specifies in the documents the role of the Contractor and the role of the Provider. Where the Contractor is required to communicate to Members, documentation may exist outside the Contractor's internal policies and procedures, generally in the form of direct Member correspondence or the Member handbook.
- 3.1.2. The Contractor shall submit all Encounter Claims Data and complete pay recovery costs for dates of service during which time this Contract was in effect, regardless of whether this Contract is terminated for any reason.
- 3.1.3. Subcontractual Relationships and Delegation
 - 3.1.3.1. The Contractor shall be accountable for any functions and responsibilities that it delegates to any subcontractor, including:
 - 3.1.3.1.1. All Subcontractors shall fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract.
 - 3.1.3.1.2. The Contractor shall evaluate the prospective Subcontractor's ability to perform the activities to be delegated.
 - 3.1.3.1.3. The Contractor shall require a written agreement with the Subcontractor that specifies the activities and report responsibilities delegated to the Subcontractor; and provides for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate.

- 3.1.3.1.4. The Contractor shall monitor the Subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.
- 3.1.3.1.5. The Contractor shall identify deficiencies or areas for improvement, and shall ensure that the Subcontractor takes corrective action.
- 3.1.3.2. Other than the Care Coordination and Covered Services provided by any PCMP, the Contractor shall not subcontract more than forty percent (40%) of its responsibilities under the Contract, based on the total annual Contract value, to any other entity and it shall not subcontract more than twenty percent (20%) of its responsibilities under the Contract, based on the total annual Contract value, to any single entity.
- 3.1.3.3. The Contractor shall not enter into any agreement with a Subcontractor or have any Subcontractor begin work in relation to the Contract until it has received the express, written consent of the Department to subcontract with the specific Subcontractor. This consent requirement shall only apply to subcontracts that relate to ten percent (10%) or more of the responsibilities under the Contract, based on the total annual Contract value.
- 3.1.3.4. Any agreement the Contractor has with a Subcontractor shall be in writing and shall require compliance with all of the terms in this Contract.

3.2. CONTRACTOR RESPONSIBILITIES AND REGULATORY COMPLIANCE

- 3.2.1. The Contractor shall provide administrative services under the terms set forth in this Contract. The Contractor shall be licensed pursuant to Section 10-16-401, et seq., C.R.S., as a Health Maintenance Organization.
- 3.2.2. The Contractor shall notify the Department, within two (2) business days, of any action on the part of the Colorado Commissioner of Insurance, suspending, revoking, denying renewal, or notifying the Contractor of any noncompliance pursuant to Section 10-16-401, et seq, C.R.S. Any revocation, withdrawal or non-renewal of necessary licenses, certifications, approvals, insurance, permits, etc. required for the Contractor to properly perform this Contract and/or failure to notify the Department as required by this section, may be grounds for the immediate termination of this Contract by the Department for default.
- 3.2.3. The Contractor shall meet the solvency standards set forth in Section 10-16-401, et seq, C.R.S. and its implementing regulations and any other applicable regulations. The Contractor shall notify the Department, within two (2) business days, of having knowledge or reason to believe that it does not meet the solvency standards specified herein. Failure to meet the solvency standards and/or failure to notify the Department as required by this section may be grounds for the immediate termination of this Contract by the Department for default.

3.3. PERSONNEL

- 3.3.1. The Contractor shall provide the following positions, defined as Key Personnel, in relation to the Contract:

- 3.3.1.1. Contract Manager
 - 3.3.1.1.1. The Contract Manger shall devote one hundred percent (100%) of his or her time to this Contract.
 - 3.3.1.1.2. The Contract Manager shall be the Department’s primary point of contact for contract and performance issues and responsibilities.
 - 3.3.1.1.3. All communication between the Department and the Contractor shall be facilitated by the Contract Manager.
 - 3.3.1.1.4. The Contract Manager shall ensure that all Contract obligations are in compliance with all state and federal laws, regulations policies and procedures and with the requirements of the Contract.
- 3.3.1.2. Financial Manager
 - 3.3.1.2.1. The Financial Manager shall devote at least twenty-five percent (25%) of his or her time to this Contract.
 - 3.3.1.2.2. The Financial Manager shall be responsible for the implementation and oversight of the budget, accounting systems and all other financial operations of the Contractor.
 - 3.3.1.2.3. The Financial Manager shall ensure that all financial operations of the Contractor are in compliance with all state and federal laws, regulations policies and procedures and with the requirements of the Contract.
- 3.3.1.3. Medical Director
 - 3.3.1.3.1. The Medical Director shall devote at least thirty percent (30%) of his or her time to this Contract.
 - 3.3.1.3.2. The Medical Director shall be a physician licensed by the State of Colorado and certified by the Colorado Board of Medical Examiners.
 - 3.3.1.3.3. The Medical Director shall be responsible for the implementation of all clinical and/or medical programs implemented by the Contractor.
 - 3.3.1.3.4. The Medical Director shall ensure that all clinical and/or medial programs implemented by the Contractor are implemented and operated in compliance with all state and federal laws, regulations policies and procedures and with the requirements of the Contract.
- 3.3.2. Each Key Personnel position shall be filled by separate and distinct individuals. No individual shall be allowed to fulfill multiple Key Personnel positions simultaneously.
- 3.3.3. Each Key Personnel shall be available in person or by phone for meetings with the Department monthly or as often as determined by the Department.
- 3.3.4. The Contract Manager shall perform their responsibilities out of an office that is either located within the Contractor’s Service Area or located in the Denver metro area.
- 3.3.5. Other Staff Functions
 - 3.3.5.1. The Contractor shall provide staff necessary to ensure that the following functions are performed, in addition to those of the Key Personnel:

- 3.3.5.1.1. Outcomes and Performance Improvement Management, including overseeing Member and administrative outcomes, coordinating quality improvement activities across the Contractor's Service Area, ensuring alignment with federal and state guidelines, and setting internal performance goals and objectives.
- 3.3.5.1.2. Medical Management and Care Coordination Activities, including assisting providers and Members in rendering and accessing necessary and appropriate services and resources.
- 3.3.5.1.3. Communications Management, including organizing, developing, modifying and disseminating information, by way of written material and forums, to providers and Members.
- 3.3.5.1.4. Provider Relations and Network Management, including establishing agreements with Primary Care Medical Providers (PCMPs), establishing all other formal and informal relationships with providers, provider education, data-sharing, and addressing providers' questions and concerns.
- 3.3.6. The Contractor shall provide the Department with an organizational chart listing all positions within the Contractor's organization that are responsible for the performance of any activity related to the Contract, their hierarchy and reporting structure and the names of the individuals fulfilling each position, within thirty (30) days of the Contract's Effective Date. The organizational chart shall contain accurate and up-to-date telephone numbers and email addresses for each individual listed.
 - 3.3.6.1. DELIVERABLE: Organizational Chart
 - 3.3.6.2. DUE: Thirty (30) days from the Contract's Effective Date
- 3.3.7. Contractor shall provide the Department with the opportunity to approve new Key Personnel working on the Contract. Any new Key Personnel shall have, at a minimum, the same qualifications as the individual previously fulfilling that position. The Contractor shall deliver an updated Organizational Chart within five (5) days of any change in Key Personnel or request from the Department for an updated Organizational Chart. The Contractor shall deliver to the Department an interim plan for fulfilling any vacant position's responsibilities and the plan for filling the vacancy.
 - 3.3.7.1. DELIVERABLE: Updated Organizational Chart
 - 3.3.7.2. DUE: Five (5) days from any change in Key Personnel or from the Department's request for an updated Organizational Chart
- 3.3.8. The Contractor shall appoint any new Key Personnel only after a candidate has been approved by the Department to fill a vacancy.

- 3.3.9. The Department may request the removal from work on the Contract of employees or agents of the Contractor whom the Department justifies as being incompetent, careless, insubordinate, unsuitable or otherwise unacceptable, or who's continued employment on the Contract the Department deems to be contrary to the public interest or not in the best interest of the Department. For any requested removal of Key Personnel, the Department shall provide written notice to Contractor identifying each element of dissatisfaction with each Key Personnel, and Contractor shall have ten (10) business days from receipt of such written notice to provide the Department with a written action plan to remedy each stated point of dissatisfaction. Contractor's written action plan may or may not include the removal of Key Personnel from work on the Contract.
- 3.3.10. Training of Contractor Employees
 - 3.3.10.1. The Contractor shall make appropriate staff available to participate in periodic training programs, sponsored by the Department, at the Department's direction. These programs will be designed to provide technical assistance to the Contractor with policy interpretation and coordination of services.
 - 3.3.10.2. The Contractor shall be responsible for providing any necessary Plan- or Policy-related training to Participating Providers and any Subcontractors.
 - 3.3.10.3. The Contractor shall provide cultural competency training to all of its new clinical staff members. The Contractor shall provide updated training to all staff members as needed to address changes in the training, to address issues that arise in relation to cultural competency or as requested by the Department.

3.4. CLIENT ENROLLMENT AND DISENROLLMENT

- 3.4.1. Clients in the following aid categories are eligible for enrollment under this Contract:
 - 3.4.1.1. Old Age Pension (Age 65+) (OAP-A).
 - 3.4.1.2. Old Age Pension (Age 61-64) - Supplemental Security Income (OAP-B-SSI).
 - 3.4.1.3. Aid to the Needy Disabled/Aid to the Blind - Supplemental Security Income (AND/AB-SSI).
 - 3.4.1.4. MAGI Parents/Caretakers (formally Aid to Families with Dependent Children Adults (AFDC-A))
 - 3.4.1.5. MAGI Pregnant (formally Baby Care/Kids Care Adults (BCKC-A)).
 - 3.4.1.6. MAGI Adults (formally Adults without Dependent Children (AwDC)).
 - 3.4.1.7. Medicaid Buy-In Program for Working Adults with Disabilities (Adult Buy-In).
- 3.4.2. Enrollment
 - 3.4.2.1. Enrollment Requirements
 - 3.4.2.1.1. Enrollment in the Contractor's Plan shall be voluntary.
 - 3.4.2.1.2. Members who are Disenrolled from the Contractor's Plan solely because the Member loses Medicaid eligibility for a period of two (2) months or less, shall be reenrolled with the Contractor's Plan upon regaining eligibility within the two (2) month period.

- 3.4.2.1.3. The Contractor shall not discriminate against Clients eligible to enroll on the basis of race, color or national origin, and shall not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin. The Contractor shall also not discriminate against Clients eligible to enroll on the basis of health status or need for health care services.
- 3.4.2.1.4. Once Enrolled in the Contractor's Plan a Member shall be enrolled until the Member's next Open Enrollment Period, at which time the Member shall receive an open enrollment notice. Subsequent enrollment shall be for twelve (12) months and a Member may not disenroll from the Contractor's Plan except as provided in section 3.4.3 Disenrollment.
- 3.4.2.1.5. All enrollment notices, informational materials and instructional materials relating to enrollment of Members shall be provided in a manner and format that may be easily understood and, wherever possible, at a sixth grade reading level, and must be shared with the Department's designated Contract manager for approval.
- 3.4.2.1.6. The Contractor may limit enrollment of new Clients by notifying the Department, in writing, that it will not accept new Clients as long as the enrollment limitation does not conflict with applicable statutes and regulations.
- 3.4.2.1.7. The Department will enroll Clients with the Contractor based on the Department's enrollment and reenrollment procedures. The Contractor shall accept all Clients, that the Department enrolls, that are eligible for enrollment. The Contractor shall accept individuals eligible for enrollment in the order in which they are passively enrolled or apply without restriction. The Department may enroll any Client who is included in any of the eligibility categories listed in 3.4.1.
- 3.4.2.2. A Member shall be enrolled in the Contractor's Plan effective the first day of the month following the month in which the Client enrolled.
- 3.4.3. Disenrollment
 - 3.4.3.1. The Contractor may only request disenrollment of a Member from the Contractor's Plan for cause. The Department shall review the Contractor's requests for disenrollment and may grant or reject the Contractor's request at its discretion. A disenrollment for cause may only occur under the following circumstances:
 - 3.4.3.1.1. Admission of the Member to any federal, state, or county governmental institution for treatment of mental illness, narcoticism or alcoholism, or a correctional institution.
 - 3.4.3.1.2. Receipt of comprehensive health coverage, other than Medicaid, by the Member.
 - 3.4.3.1.3. Enrollment in a Medicare MCO or capitated health plan other than such a plan offered by the Contractor.
 - 3.4.3.1.4. Child welfare eligibility status or receipt of Medicare benefits.
 - 3.4.3.1.5. Member moves out of the Contractor's service area.

- 3.4.3.1.6. The Contractor's Plan does not, because of moral or religious reasons, cover the service the Member seeks.
- 3.4.3.1.7. The Member needs related services to be performed at the same time, not all related services are available within the network and a physician determines that receiving the services separately would subject the Member to unnecessary risk.
- 3.4.3.1.8. Abuse or intentional misconduct consisting of any of the following:
 - 3.4.3.1.8.1. Behavior of the Member that is disruptive or abusive to the extent that the Contractor's ability to furnish services to either the Member or other Members is impaired.
 - 3.4.3.1.8.2. A documented, ongoing pattern of failure on the part of the Member to keep scheduled appointments or meet any other Member responsibilities.
 - 3.4.3.1.8.3. Behavior of the Member that poses a physical threat to the provider, to other provider or Contractor staff or to other Members.
 - 3.4.3.1.8.4. The Contractor shall provide one oral warning, to any Member exhibiting abusive behavior or intentional misconduct, stating that continuation of the behavior or misconduct will result in a request for disenrollment. If the Member continues the behavior or misconduct after the oral warning, the Contractor shall send a written warning that the continuation of the behavior or misconduct will result in disenrollment from the Contractor's Plan. The Contractor shall send a copy of the written warning and a written report of its investigation into the behavior, to the Department, no less than thirty (30) days prior to the disenrollment. If the Member's behavior or misconduct poses an imminent threat to the provider, to other provider or Contractor or to other Members, the Contractor may request an expedited disenrollment after it has provided the Member exhibiting the behavior or misconduct an oral warning.
 - 3.4.3.1.8.4.1. DELIVERABLE: Copy of the Written Warning Sent to the Member and Written Documentation of the Member's Abusive Behavior or Intentional Misconduct.
 - 3.4.3.1.8.4.2. DUE: No less than thirty (30) days prior to disenrollment unless the Department approves expedited disenrollment
- 3.4.3.1.9. The Member commits fraud or knowingly furnishes incorrect or incomplete information on applications, questionnaires, forms or statements submitted to the Contractor as part of the Member's enrollment in the Contractor's Plan.
- 3.4.3.1.10. Any other reason determined to be acceptable by the Department.
- 3.4.3.2. Disenrollment for cause shall not include disenrollment because of:
 - 3.4.3.2.1. Adverse changes in the Member's health status.
 - 3.4.3.2.2. Change in the Member's utilization of medical services.
 - 3.4.3.2.3. The Member's diminished mental capacity.

- 3.4.3.2.4. Any behavior of the Member resulting from the Member's special needs, as determined by the Department, unless those behaviors seriously impair the Contractor's ability to furnish services to that Member or other Members.
- 3.4.3.3. The Department may disenroll any Member, who requests disenrollment, in its sole discretion.
- 3.4.3.4. The Department may disenroll a Member from the Contractor's Plan upon that Member's request. A Member (or his or her representative) may request disenrollment to the Department, either written or orally, and the Department may grant the Member's request:
 - 3.4.3.4.1. For cause, at any time. A disenrollment for cause may occur under the following circumstances:
 - 3.4.3.4.1.1. The Member moves out of the Contractor's service area.
 - 3.4.3.4.1.2. The Contractor does not, because of moral or religious objections, cover the service the Member needs.
 - 3.4.3.4.1.3. The Member needs related services to be performed at the same time, not all related services are available within the network and a physician determines that receiving the services separately would subject the Member to unnecessary risk.
 - 3.4.3.4.1.4. Administrative error on the part of the Department or its designee or the Contractor including, but not limited to, system error.
 - 3.4.3.4.1.5. Poor quality of care, as documented by the Department.
 - 3.4.3.4.1.6. Lack of access to covered services, as documented by the Department.
 - 3.4.3.4.1.7. Lack of access to providers experienced in dealing with the Member's health care needs.
 - 3.4.3.4.1.8. The Member Enrolled in the Contractor's Plan with his/her Physician and the Physician leave the Contractor.
 - 3.4.3.4.1.9. The Member is a resident of long-term institutional care (e.g. hospice or skilled nursing facility).
 - 3.4.3.4.1.10. The Member is enrolled into a Medicare managed care plan or Medicare capitated health plan other than a Plan offered by the Contractor and Contractor cannot provide the Member with reasonable access to a Medicare approved Provider or, if the Member is enrolled in a Medicare managed care plan, Contractor cannot provide the Member with Providers participating in both Plans.
 - 3.4.3.4.1.11. The Member is a foster child.
 - 3.4.3.4.1.12. The Member is in long-term community based care (e.g. HCBS waiver programs).

- 3.4.3.4.2. Without cause, under the following circumstances:
 - 3.4.3.4.2.1. A Member may request disenrollment at any time during the ninety (90) days following the date of the Member's initial enrollment with the Contractor.
 - 3.4.3.4.2.2. A Member may request disenrollment at least once every twelve (12) months after the first ninety (90) day period.
 - 3.4.3.4.2.3. A Member may request disenrollment upon automatic reenrollment under 42 CFR 438.56(g), if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.
 - 3.4.3.4.2.4. A Member may request disenrollment if the Department imposes the intermediate sanction specified in 438.702(a)(3).
- 3.4.3.5. In the event that the Department grants a request for disenrollment, the effective date of that disenrollment shall be no later than the first day of the second month following the month in which the Member files the request. If the Department fails to either approve or deny the request in this timeframe, the request shall be considered approved.
 - 3.4.3.5.1. In the event that a Member is disenrolled from the Contractor's Plan because the Member has become ineligible for Medicaid, then the effective date of disenrollment shall be the date on which the Member became ineligible.
 - 3.4.3.5.2. If a current Member of a Contractor's Plan is an inpatient of a Hospital at 11:59 p.m. the day before that Member's disenrollment from the Contractor's Plan is scheduled to take effect, disenrollment shall be postponed until the Member is discharged from the hospital. If the Member is discharged from the hospital, the new disenrollment date for that Member shall be the last day of the month following discharge.
- 3.4.4. The Contractor shall use reports and information from the Medicaid Management Information System (MMIS) to verify the Medicaid eligibility and enrollment in the Contractor's Plan for its Members. These reports shall include, at a minimum, all of the following:
 - 3.4.4.1. Disenrollment Report (R0305) and (M0305).
 - 3.4.4.2. Prepaid Health Plan (PHP) Enrollment Change Report (R0310).
 - 3.4.4.3. PHP Current Enrollment Report (R0315).
 - 3.4.4.4. PHP New Enrollee Report (R0325 and M0325).
 - 3.4.4.5. Capitation Summary Report (R0360).
 - 3.4.4.6. When available, Benefit Enrollment and Maintenance Transaction report (ANSI X 12N 834).
 - 3.4.4.7. When available, Payroll Deducted and Other Group Premium Payment for Insurance Products Transaction report (ANSI X 12N 820) for capitation.

3.5. COVERED SERVICES

3.5.1. Health Coverage

- 3.5.1.1. The Contractor shall provide or shall arrange to have provided all Covered Services specified in Exhibit B. The Contractor shall provide Care Coordination, Utilization Management and Medical Management for Members to promote the appropriate and cost-effective utilization of Covered Services. The Contractor shall ensure that the services provided are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- 3.5.1.2. The Contractor shall provide the same standard of care for all Members regardless of eligibility category and shall make all Covered Services as accessible in terms of timeliness, amount, duration and scope, to Members, as those services are to non-Member Medicaid recipients within the same area.
- 3.5.1.3. The Contractor shall not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness or condition of the Member.

3.5.2. Coverage Limitations

- 3.5.2.1. The Contractor shall cover any service that is required under any State or Federal statute, regulation or rule, or is defined as Medically Necessary in Exhibit B.
 - 3.5.2.1.1. The Contractor may use its quality committee to place appropriate limits on service so long as the limits allow for services furnished to reasonably be expected to achieve their purpose and the limits are in accordance with the Department's State Plan.
- 3.5.2.2. The Contractor shall not be liable for any Covered Services incurred prior to the Member's effective date of coverage under this Contract or after the date of termination of coverage.
- 3.5.2.3. The Contractor shall be authorized to impose copayments in accordance with the Medicaid fee-for-service regulations.

3.5.3. Covered Services Through Participating Providers

- 3.5.3.1. Covered Services shall be made available in the Service Area only through Participating Providers or non-Participating Providers authorized by the Contractor. A Participating Provider is an organization or agency that has contracts or affiliations with the Contractor to render Covered Services.
- 3.5.3.2. Except for Emergency Services and Urgently Needed Services, the Contractor shall have no liability or obligation to pay for any service or benefit sought or received by any Member from any non-Participating Provider unless:
 - 3.5.3.2.1. Special arrangements or Referrals are made by a Participating Provider or the Contractor, as specified in the Member handbook; or
 - 3.5.3.2.2. The Member is receiving a service as described in Section 2.6.5.1.

3.5.4. Coverage of Specific Services and Responsibilities

3.5.4.1. Emergency Services

- 3.5.4.1.1. The Contractor shall ensure that Members within the Service Area shall have access to Emergency Services on a twenty-four (24) hour per day, seven (7) day per week basis.
- 3.5.4.1.2. Members temporarily out of the Service Area may receive out-of-area Emergency Services and Urgently Needed Services, as specified in Exhibit B.
- 3.5.4.1.3. The Contractor shall not require prior authorization for Emergency Services or Urgently Needed Services.
- 3.5.4.1.4. The Contractor may not deny payment for Emergency Services if a non-contracted provider provides the Emergency Services or when a representative of the Contractor instructs the Member to seek Emergency Services.
- 3.5.4.1.5. The attending emergency physician, or the provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on the Contractor as responsible for coverage and payment.
- 3.5.4.1.6. A Member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member.
- 3.5.4.2. Emergency Ambulance Transportation
 - 3.5.4.2.1. The Contractor shall make reasonable efforts to ensure that Members within the Service Area shall have access to emergency ambulance transportation on a twenty-four (24) hour per day, seven (7) day per week basis. This includes providing access for Members with medical, physical, psychiatric or behavioral emergencies.
- 3.5.4.3. Verification of Medical Necessity for Emergency Services
 - 3.5.4.3.1. The Contractor may require that all claims for Emergency Services be accompanied by sufficient documentation to verify nature of the services. The Contractor shall not deny benefits for conditions which a reasonable person outside of the medical community would perceive as Emergency Medical Conditions. The Contractor shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.
- 3.5.4.4. Poststabilization Care Services
 - 3.5.4.4.1. The Contractor shall provide coverage for Poststabilization Care Services in compliance with 42 C.F.R. Section 438.114.
- 3.5.4.5. Newborn Services
 - 3.5.4.5.1. The Contractor shall furnish Covered Services to newborns of mothers who are Members, who are determined Medicaid eligible, only for the period of the mother's hospitalization.
- 3.5.4.6. Coverage of Prescription Drugs
 - 3.5.4.6.1. Medicare Prescription Drug, Improvement, and Modernization Act (MMA)

- 3.5.4.6.1.1. The Contractor shall not provide drugs described in Medicare Part D to individuals eligible for both Medicare and Medicaid.
- 3.5.4.6.1.2. The Contractor shall comply with all federal and state statutes and regulations regarding prescription drug benefits described in Medicare Part D for individuals eligible for both Medicare and Medicaid.
- 3.5.4.6.1.3. The Contractor shall cover excluded Part D drugs as defined in 42 U.S.C. §1395w-101, *et seq.*, for individuals eligible for both Medicare and Medicaid in the same manner and to the same extent as they cover excluded Part D drugs for all other eligible Medicaid clients.
- 3.5.4.6.2. The Contractor shall provide coverage only for prescription drugs approved for use and reimbursed by the Medicaid Program, including those products that require prior authorization by the Medicaid Program. Such Covered Drugs must be prescribed and dispensed within the Contractor's parameters for pharmaceuticals, and as follows:
 - 3.5.4.6.2.1. The Contractor shall only provide coverage for drugs that are rebateable in accordance with 42 U.S.C. Section 1396r-8.
 - 3.5.4.6.2.2. The Contractor may establish a drug formulary, for all Medically Necessary Covered Drugs with its own prior authorization criteria provided the Contractor includes each therapeutic drug category in the Medicaid program.
 - 3.5.4.6.2.3. The Contractor shall provide a Covered Drug if there is a Medical Necessity which is unmet by the Contractor's formulary product.
 - 3.5.4.6.2.4. The Contractor may authorize at least a seventy-two (72) hour supply of outpatient Covered Drugs in an Emergency situation when the prior authorization request is incomplete or additional information is needed. Emergency prior authorization may be given retroactively if the drug had to be dispensed immediately for the Member's well-being.
- 3.5.4.7. Responsibility Regarding Psychiatric and Medical Diagnoses
 - 3.5.4.7.1. Inpatient Hospital Services
 - 3.5.4.7.1.1. The Contractor shall be responsible for inpatient hospital stays based on the primary diagnosis that requires inpatient care.
 - 3.5.4.7.1.1.1. The Contractor shall be financially responsible for the hospital stay when the Member's primary diagnosis is medical in nature, even when the medical diagnosis includes some psychiatric procedures.
 - 3.5.4.7.1.1.2. The Contractor shall not be financially responsible for inpatient services when the Client's primary diagnosis is psychiatric in nature, even when the psychiatric hospitalization includes some medical conditions or procedures to treat a secondary medical diagnosis
 - 3.5.4.7.1.1.3. The Contractor shall not be responsible for the hospital stay when the primary diagnosis is for substance abuse rehabilitation.

- 3.5.4.7.2. Coverage for Emergency Services
 - 3.5.4.7.2.1. The Contractor shall be responsible for Emergency Services when the Member's primary diagnosis is medical in nature, even when the medical diagnosis includes some psychiatric conditions or procedures.
 - 3.5.4.7.2.2. The Contractor shall not be responsible for Emergency Services when the primary diagnosis is psychiatric in nature even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis.
 - 3.5.4.7.3. The Contractor's responsibility for the Covered Services of outpatient Hospital Services is based on the diagnosis and the billing procedures of the Hospital.
 - 3.5.4.7.3.1. For any procedure billed in a UB-92/ANSI 837I, Health Care Claim Institutional (ANSI 837I) format, the Contractor shall be responsible for all Covered Services associated with a Member's outpatient Hospital Services Covered Services, including all psychiatric, medical and facility Covered Services, if:
 - 3.5.4.7.3.1.1. The procedure is billed on a UB-92/ANSI 837I claim form, and
 - 3.5.4.7.3.1.2. The principal diagnosis is a medical diagnosis.
 - 3.5.4.7.3.2. For any procedure billed in a HCFA-1500/ANSI 837P, Health Care Claim Professional Format, the Contractor shall be responsible for all Covered Services associated with a Member's outpatient Hospital Services Covered Services, including all psychiatric, medical and facility Covered Services, if:
 - 3.5.4.7.3.2.1. The procedure is billed on a HCFA-1500/ANSI 837P claim form, and
 - 3.5.4.7.3.2.2. The Covered Services are not listed as a required Behavioral Health Organization (BHO) Covered Service as defined in 10 C.C.R. 2505-10, Section 8.212.4.A. Diagnoses and procedures covered by the BHOs are listed in Exhibit F.
- 3.5.4.8. Wrap Around (Fee For Service) Benefits
 - 3.5.4.8.1. The Contractor shall communicate to its Participating Providers and Members information about Medicaid Wrap Around Benefits, which are not Covered Services under this Contract but are available to Members under Medicaid fee for service (FFS).
 - 3.5.4.8.2. The Contractor shall instruct its Participating Providers on how to refer a Member for such services. The Contractor shall advise Participating Providers of Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) support services that are available through other entities, including, but not limited to local public health departments and Healthy Communities. The Contractor shall also advise post partum or breast-feeding or pregnant women of the special supplemental food program (Women, Infants, and Children), state's special assistance program for substance abusing pregnant women, and enhanced prenatal care services.

- 3.5.4.8.3. The Contractor shall inform its Home Health Services Providers and Members that Home Health Services after sixty (60) consecutive days are not Covered Services but are available to Members under FFS and require prior authorization. If Home Health Services after sixty (60) consecutive days are anticipated, the Contractor shall ensure that, at least thirty (30) days prior to the sixtieth (60th) day of Home Health Services, its Home Health Services Providers coordinate prior authorization with the Single Entry Point Agency for adult Members and with the Medicaid Fiscal Agent for children.
- 3.5.4.8.4. The Contractor shall inform its Participating Providers of the services provided by the Behavioral Health Organizations (BHOs).

3.6. SERVICE DELIVERY

3.6.1. Access

3.6.1.1. Access to Services

- 3.6.1.1.1. The Contractor shall comply with all requirements described in §10-16-704 C.R.S. The Contractor shall attempt to include both Essential Community Providers, as designated at 10 C.C.R. 2505-10, §8.205.5.A, and other Providers in its network of providers.
- 3.6.1.1.2. The Contractor shall maintain and monitor a network of Participating Providers that is sufficient to provide adequate access to all Covered Services. In order for the Contractor's network to be considered to provide adequate access, the Contractor shall ensure a minimum Provider to Member caseload ratio as follows:
- 3.6.1.1.2.1. 1:2000 Primary Care Medical Provider to Member ratio.
- 3.6.1.1.2.2. 1:2000 Physician specialist to Member ratio. Physician specialist includes Physicians designated to practice Cardiology, Otolaryngology/ENT, Endocrinology, Gastroenterology, Neurology, Orthopedics, Pulmonary Medicine, General Surgery, Ophthalmology and Urology.
- 3.6.1.1.2.3. Physician specialists designated to practice Gerontology, Internal Medicine, OB/GYN and Pediatrics shall be counted as either a PCMP or Physician specialist, but not both.
- 3.6.1.1.3. The Contractor shall have written agreements with all providers in its network.
- 3.6.1.1.4. The Contractor shall verify that all primary care providers in its network are contracted Primary Care Medical Providers (PCMPs) in the ACC.
- 3.6.1.1.5. The Contractor shall provide female Members with direct access to a women's health specialist within the network for Covered Services necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated PCMP if that source is not a women's health specialist.
- 3.6.1.1.6. The Contractor shall ensure that Members in the Service Area have access to specialists and other Medicaid providers promptly without compromising the Member's quality of care or health.

- 3.6.1.1.7. The Contractor shall provide for a Member to receive a second opinion from a qualified health care professional within the network, or arrange for the Member to obtain one outside the network if there is no other qualified health care professional within the network, at no cost to the Member.
- 3.6.1.1.8. The Contractor shall ensure that all Members have appropriate access to certified nurse practitioners and certified nurse midwives, as set forth at 42 C.F.R. §438.102(a), as amended, and §26-4-202(1)(j), C.R.S., as amended, through either Participating Provider agreements or Referrals. This provision shall not be interpreted as requiring the Contractor to provide any services that are not Covered Services under this Contract.
- 3.6.1.1.9. The Contractor shall not restrict any Member's choice of the Provider from which the Member receives family planning services or supplies.
- 3.6.1.1.10. The Contractor shall maintain, staff and publish the number for at least one (1) toll free telephone line that Members may call regarding customer service or Care Coordination issues.
 - 3.6.1.1.10.1. The Contractor shall provide both English- and Spanish-speaking representatives to assist English- and Spanish-speaking Members and Clients, both through telephone conversations and in-person.
- 3.6.1.1.11. The Contractor shall develop and maintain its network so that it includes providers with the interest and expertise in serving the special populations that include, but are not limited to:
 - 3.6.1.1.11.1. The physically or developmentally disabled.
 - 3.6.1.1.11.2. Adults and the aged.
 - 3.6.1.1.11.3. Non-English speakers.
 - 3.6.1.1.11.4. Expansion population.
 - 3.6.1.1.11.5. Members with complex behavioral or physical health needs.
 - 3.6.1.1.11.6. Members with Human Immunodeficiency Virus (HI)
- 3.6.1.1.12. The Contractor's network shall provide the Contractor's Members with a meaningful choice selecting a PCMP.
 - 3.6.1.1.12.1. If a Member within the Service Area selects a provider that has not entered into an agreement with the Contractor, the Contractor shall make an effort to enroll the provider.
 - 3.6.1.1.12.1.1. The Contractor shall make an initial contact, through any method allowed by the Department and state and federal statues, regulations, policies, or procedures, with the provider to attempt to enroll the provider in the Contractor's network.
 - 3.6.1.1.12.1.2. If the Contractor is unsuccessful in its initial contact, then the Contractor shall make one (1) follow-up contact to attempt to enroll the provider in the Contractor's network.
- 3.6.1.2. Out of Network Providers

- 3.6.1.2.1. In the event that the Contractor is unable to provide any Covered Service to a Member from a Participating Provider within its network, then the Contractor shall provide that service through a Provider that is not within its network promptly and without compromising the Member's quality of care or health.
- 3.6.1.2.2. The Contractor shall ensure that the cost to the Member for any service provided by the Contractor from a Provider that is not within the Contractor's network is not greater than the cost to that same Member if that Member had received the service from a Provider that was within the Contractor's network.
 - 3.6.1.2.2.1. The Contractor shall work with any Provider that is not within its network with respect to any payment that the Contractor must make to the Provider to meet the requirements of this section 2.5.1.2. All payments from the Contractor to a Provider that is not within the Contractor's network shall be made in accordance with §26-4-404, C.R.S., unless otherwise negotiated between the Contractor and that Provider.
- 3.6.1.3. Geographic Access
 - 3.6.1.3.1. The Contractor shall establish and maintain adequate arrangements to ensure reasonable proximity of Participating Providers to the residence of Members so as not to result in unreasonable barriers to access and to promote continuity of care, taking into account the usual means of transportation ordinarily used by Members in accordance with 42 CFR 438.6(k)(2).
 - 3.6.1.3.2. The Contractor's PCMP network shall have a sufficient number of PCMPs so that each Member has a PCMP and each Member has their choice of at least two (2) PCMPs within their zip code or within thirty (30) minutes of driving time from their location, whichever area is larger. For rural and frontier areas, the Department may adjust this requirement based on the number and location of available providers.
- 3.6.1.4. Service Availability
 - 3.6.1.4.1. The Contractor's PCMP network shall provide for extended hours on evenings and weekends and alternatives for emergency room visits for after-hours urgent care. The Contractor will determine the appropriate requirements for the number of extended hours and weekend availability based on the needs of the Contractor's Service Area, and submit these requirements to the Department for approval. The Contractor shall assess the needs of the Contractor's Service Area on a regular basis, no less often than quarterly, and submit a request to the Department to adjust its requirements accordingly.
 - 3.6.1.4.1.1. DELIVERABLE: Documentation of Service Availability Requirements
 - 3.6.1.4.1.2. DUE: Thirty (30) days from the Effective Date and any time that the Contractor requests a change to its requirements.

- 3.6.1.4.2. The Contractor shall ensure that Members, including Members with Disabilities, have a point of access to appropriate services available on a twenty-four (24) hour per day basis and have written policies and procedures for how the Contractor will meet this requirement. The Contractor shall communicate this information to Participating Providers and Members, and have a routine monitoring mechanism to ensure that Participating Providers promote and comply with these policies and procedures. These policies and procedures shall address, at a minimum, the following requirements:
 - 3.6.1.4.2.1. Emergency Services shall be available twenty-four (24) hours per day, seven (7) days per week.
 - 3.6.1.4.2.2. The Contractor shall have a comprehensive plan for triage of requests for services on a twenty-four (24) hour seven (7) day per week basis, including all of the following:
 - 3.6.1.4.2.2.1. Immediate Medical Screening Exam by the PCMP or Hospital emergency room.
 - 3.6.1.4.2.2.2. Access to a qualified health care practitioner via live telephone coverage either on-site, call-sharing, or answering service.
 - 3.6.1.4.2.2.3. Practitioner backs up covering all specialties.
- 3.6.1.5. Scheduling and Wait Times
 - 3.6.1.5.1. The Contractor shall establish clinically appropriate scheduling guidelines for various types of appointments necessary for the provision of primary and specialty care including, but not limited to:
 - 3.6.1.5.1.1. Routine physicals.
 - 3.6.1.5.1.2. Diagnosis and treatment of acute pain or injury.
 - 3.6.1.5.1.3. Follow-up appointments for chronic conditions.
 - 3.6.1.5.2. The Contractor shall ensure that its scheduling guidelines meet, at a minimum, all of the following standards:
 - 3.6.1.5.2.1. Urgently Needed Services provided within forty-eight (48) hours of notification of the Member's need for those services to the Member's PCMP or the Contractor.
 - 3.6.1.5.2.2. Non-urgent, symptomatic care scheduled within two (2) weeks of the Member's request for services.
 - 3.6.1.5.2.3. Adult, non-symptomatic well care physical examinations scheduled within forty five (45) days.
 - 3.6.1.5.3. The Contractor shall make these scheduling guidelines available to the Department for the Department's review. In the event that the Department determines that the guidelines are unacceptable to the Department, then the Contractor shall work with the Department to modify those guidelines to create acceptable guidelines.
 - 3.6.1.5.3.1. DELIVERABLE: Documentation of Scheduling Guidelines.

- 3.6.1.5.3.2. DUE: Thirty (30) days from the Effective Date.
- 3.6.1.5.4. The Contractor shall communicate all scheduling guidelines in writing to Participating Providers. The Contractor shall create and maintain an effective organizational process for monitoring scheduling and wait times, identifying scheduling and wait time issues that do not comply with its guidelines, and taking appropriate corrective action.
- 3.6.2. Service Area Standards
 - 3.6.2.1. The Department shall make any final determination regarding the Contractor's suitability for providing Covered Services to Members within any specific Service Area.
 - 3.6.2.2. The Contractor shall provide the Department with written notice and a service plan analysis when seeking to expand into a new Service Area or expand the eligibility categories served. Such written notice and analysis shall include, but not be limited to:
 - 3.6.2.2.1. The name of the proposed county or counties in which the Contractor seeks to expand or the categories of populations to be served, and;
 - 3.6.2.2.2. An analysis by the Contractor concerning whether its Provider network is adequate to serve Clients in the proposed county, able to provide the full scope of benefits, and can comply with the standards for access to care as specified in this Contract.
- 3.6.3. Selection and Assignment of Primary Care Medical Providers
 - 3.6.3.1. The Contractor's network shall provide the Contractor's Members with a meaningful choice in selecting a PCMP. The Contractor shall allow, to the extent possible and appropriate, each Member to choose a PCMP.
 - 3.6.3.1.1. The Contractor shall not impose any limitation on a Member's ability to select or change that Member's PCMP that is more restrictive than the Member's right to disenroll from the Contractor's Plan.
 - 3.6.3.2. The Contractor shall in no way prohibit or restrict a Participating Provider, who is acting within the lawful scope of practice, from advising a Member about any aspect of his or her health status or medical care, advocating on behalf of a Member, advising about alternative treatments that may be self-administered, including the risks, benefits and consequences of treatment or non-treatment so that the Member receives the information needed to decide among all available treatment options and can make decisions regarding the Member's own health care, regardless of whether such care is a Covered Service under this Contract. This section shall not be construed as requiring the Contractor to provide any service, treatment or benefit that is not a Covered Service under this Contract.

3.7. CARE COORDINATION AND MEDICAL MANAGEMENT

- 3.7.1. Medical management support

- 3.7.1.1. The Contractor shall use, and recommend to PCMPs, traditional and non-traditional medical management practices and tools to ensure optimal health outcomes and manage costs for the Department and the Contractor's Members. The Formal System of Care Coordination report shall include at least one planned method of Medical Management Support and an assessment of the efficacy or success of the last method tried. These practices and tools may include, but are not limited to, any of the following:
 - 3.7.1.1.1. Traditional methods:
 - 3.7.1.1.1.1. Integrating disease management into the care of Members with multiple chronic conditions.
 - 3.7.1.1.1.2. Catastrophic case management.
 - 3.7.1.1.1.3. Coordination of medical services for Members with serious, life-changing, and possibly life-threatening, illnesses and injuries.
 - 3.7.1.1.2. Innovative and proven or promising practices:
 - 3.7.1.1.2.1. Technologically enhanced communication, such as cell phone messages, email communication and text messaging.
 - 3.7.1.1.2.2. Providing PCMPs with tools and resources to support informed medical decision-making with Members.
 - 3.7.1.1.2.3. Alternate formats for delivering care.
 - 3.7.1.1.2.4. Methods for diversion to the most appropriate care setting.
 - 3.7.1.1.2.5. The Contractor shall use a method to detect inappropriate utilization of services and shall develop methods for diversion to the most appropriate care setting. Both shall be described in the Practice Support Plan.
- 3.7.1.2. The Department may review the Contractor's Medical Management practices and tools during the annual site review. In the event that the Department determines any practice or tool to be ineffective, inappropriate or otherwise unacceptable, the Contractor shall cease using or recommending that practice or tool immediately upon notification by the Department of its unacceptability. The Department may request that the Contractor devise a method to evaluate the tool's efficacy. In the event that the Department requests this, the Contractor shall develop a method for evaluation and implement that evaluation within thirty days of the request.
- 3.7.2. Care Coordination
 - 3.7.2.1. The Contractor shall ensure Care Coordination is comprehensive, client and family centered, and integrated.

- 3.7.2.2. The Contractor shall ensure Care Coordination that reflects the needs of Members to achieve their desired health outcomes in an efficient and responsible manner. The Contractor shall document the Care Coordination care plan that includes documentation of the Member's desired health outcomes and identifies other members of that Member's Care Coordination team. The Department may request a sample of care plans at any time. The Contractor may allow the PCMPs with which it contracts or other Subcontractors to perform some or all of the Care Coordination activities, but the Contractor shall be responsible for the ultimate delivery of Care Coordination services.
- 3.7.2.2.1. In the event that the Contractor allows a PCMP or other Subcontractor to perform any Care Coordination activities, the agreement with that PCMP or other Subcontractor shall comply with all applicable requirements of this Contract.
- 3.7.2.3. Regardless of its relationships or contracts with PCMPs or Subcontractors, the Contractor shall:
 - 3.7.2.3.1. Assess current Care Coordination services provided to each of its Members to determine if the providers involved in each Member's care are providing necessary Care Coordination services and which Care Coordination services are insufficient or are not provided. This assessment could be accomplished through random site reviews, in-practice activities conducted by Contractor's practice transformation personnel, collection of practice reporting, and similar Contractor oversight functions.
 - 3.7.2.3.2. Provide all Care Coordination services that are not provided by another source.
 - 3.7.2.3.3. Work with providers who are responsible for the Member's care to develop a plan for regular communication with the person(s) who are responsible for the Member's Care Coordination.
 - 3.7.2.3.4. Reasonably ensure that all Care Coordination services, including those provided by other individuals or entities, meet the needs of the Member.
 - 3.7.2.3.5. Ensure all members of the Care Coordination team have access to an integrated care plan elements across provider and community organizations, including a comprehensive psychosocial assessment and a multidimensional plan addressing social, physical and behavioral health needs.
- 3.7.2.4. The Contractor shall develop a formal system of Care Coordination for its Members. All elements of the formal system of Care Coordination shall be documented in the care plan. This formal system shall have comprehensive, client/family centered, integrated Care Coordination.
 - 3.7.2.4.1. Comprehensive Care Coordination components include:
 - 3.7.2.4.1.1. Assessing the Member's health and health behavior risks and medical and non-medical needs, including determining if a care plan exists and creating a care plan if one does not exist and is needed.

- 3.7.2.4.1.2. Linking Members both to medical services and to non-medical, community-based services, such as child care, food assistance, services supporting elders, housing, utilities assistance and other non-medical supports as necessary. Assessing support needs and responding appropriately from providing Members the necessary contact information for the service to arranging the services and acting as a liaison between medical providers, non-medical providers and the Member.
- 3.7.2.4.1.3. Providing assistance during care transitions from hospitals or other care institutions to home- or community-based settings or during other transitions, such as the transition from children's health services to adult health services or from hospital or home care to care in a nursing facility. This assistance shall promote continuity of care and prevent unnecessary re-hospitalizations and document and communicate necessary information about the Member to the providers, institutions and individuals involved in the transition.
- 3.7.2.4.1.4. The Contractor shall provide, or work with community based organizations to arrange for, an individual to act as a care coordinator for each Member during any transitions in this section. This individual shall communicate with every member to which they are assigned, once while they are in the hospital and again within forty-eight (48) hours of that Member's discharge, to help the Member receive the assistance that Member needs during their transition.
- 3.7.2.4.1.5. Providing solutions to problems encountered by providers or Members in the provision or receipt of care.
- 3.7.2.4.1.6. The Contractor shall use its existing grievance process to document all problems presented by Members in the provision or receipt of care and the solutions given to the Member. The Contractor shall also document problems presented by providers in the provision of care and the solutions provided to the provider. The Department may review any of the documented solutions and, should the Department determine the solution to be insufficient or otherwise unacceptable, may direct the Contractor to find a different solution or follow a specific course of action.
- 3.7.2.4.1.7. Informing the Members of the Department's Medicaid ombudsman to assist the Member in resolving health care issues and filing grievances.
- 3.7.2.4.1.8. Following up with Members to assess whether the Member has received needed services and if the Member is on track to reach their desired health outcomes.
- 3.7.2.5. Client/Family Centered characteristics include:
 - 3.7.2.5.1. Ensuring that Members, and their families if applicable, are active participants in the Member's care, to the extent that they are able and willing.
 - 3.7.2.5.2. Providing care and Care Coordination activities that are linguistically appropriate to the Member and are consistent with the Member's cultural beliefs and values.

- 3.7.2.5.3. Providing Care Coordination that is responsive to the needs of special populations, including, but not limited to:
 - 3.7.2.5.3.1. The physically or developmentally disabled
 - 3.7.2.5.3.2. Adults and the aged
 - 3.7.2.5.3.3. Non-English speakers
 - 3.7.2.5.3.4. All expansion populations, as defined in Colorado House Bill 09-1293, the Colorado Health Care Affordability Act
 - 3.7.2.5.3.5. Members in need of assistance with medical transitions
 - 3.7.2.5.3.6. Members with complex behavioral or physical health needs
- 3.7.2.5.4. Providing Care Coordination that aims to keep Members out of a medical facility or institutional setting and provide care in the Member's community or home to the greatest extent possible. The Contractor shall ensure that all Care Coordination activities comply with the Supreme Court decision in *Olmstead v. L. C.* (527 U.S. 581 (1999)).
- 3.7.2.6. Integrated Care Coordination characteristics include:
 - 3.7.2.6.1. Ensuring that physical, behavioral, long-term care, social and other services are continuous and comprehensive and the service providers communicate with one another in order to effectively coordinate care.
 - 3.7.2.6.2. Providing services that are not duplicative of other services and that are mutually reinforcing.
 - 3.7.2.6.3. Implementing strategies to integrate member care such as:
 - 3.7.2.6.3.1. Developing a knowledge base of care providers, case management agencies and available services, both within the Contractor's network and the Members' communities.
 - 3.7.2.6.3.2. Becoming familiar with the Department's initiatives and programs.
 - 3.7.2.6.3.3. Knowing the eligibility criteria and contact points for community-based service available to the Member's in the Contractor's Region, subject to the Department's direction.
 - 3.7.2.6.3.4. Identifying and addressing barriers to health in the in the Contractor's region, such as member transportation issues or medication management challenges.
- 3.7.2.7. The Department may review the Contractor's formal system of Care Coordination at any time. The Department may direct changes in the Contractor's system of Care Coordination in the event that it determines any aspect of the system to be insufficient, inappropriate or otherwise unacceptable, for any reason. The Contractor shall immediately implement any changes directed by the Department and update its documentation of its formal system of Care Coordination accordingly.

- 3.7.2.8. The Contractor shall document its formal system of Care Coordination and deliver this documentation to the Department within sixty (60) days of the Contract's Effective Date.
- 3.7.2.8.1. DELIVERABLE: Documented Formal System of Care Coordination
- 3.7.2.8.2. DUE: Sixty (60) days from the Effective Date
- 3.7.2.9. The Contractor shall provide the Department with an updated documentation of its formal system of Care Coordination whenever it makes any significant change to its system, when a series of minor changes have combined into a significant change from the prior system or upon the Department's request. The Contractor shall deliver this documentation to the Department within sixty (60) days of the change has occurred or from any request by the Department for updated documentation.
- 3.7.2.9.1. DELIVERABLE: Updated Documentation of Formal System of Care Coordination.
- 3.7.2.9.2. DUE: Annually, within the first three (3) months of each state fiscal year
- 3.7.2.10. The Contractor shall attempt to contact Members who access a hospital's emergency room, or are otherwise hospitalized, within thirty (30) days of the Member's discharge or emergency room visit.
- 3.7.2.10.1. The Contractor shall explain the importance of the Medical Home concept, support transitions and follow-up in primary care settings, and help when necessary to schedule an appointment with the Member's PCMP.
- 3.7.2.11. The Contractor shall provide the Department with updated documentation of its System of Care Report including, at a minimum, the following information:
- 3.7.2.11.1. Number of Members contacted within thirty (30) days of discharge.
- 3.7.2.11.2. Number of Members who received a clinic visit within 7 days of discharge from a hospital admission.
- 3.7.2.11.3. Description of the agreements that the Contractor has with all of the hospitals in its Service Area, and if those hospitals are currently notifying the contractor when a Member presents at the emergency room or is admitted to the hospital.
- 3.7.2.11.4. Numbers of members receiving face-to-face Care Coordination and number of Care Coordination activities per member.
- 3.7.2.11.5. Number and description of integrated care activities, including, but not limited to, integration with local public health agencies, Community Centered Boards (CCBs), Single Entry Points (SEPs), and Community Mental Health Centers.
- 3.7.2.11.6. Number of Members accessing the Contractor's new workforce, behavior change and self-management supports.
- 3.7.2.11.6.1. DELIVERABLE: Systems of Care Report.
- 3.7.2.11.6.2. DUE: Biannually, within the first three (3) months of the state fiscal year, and within the first three (3) months of the calendar year.

- 3.7.2.12. The Contractor shall classify each member in the Contractor's Service Area, based on their care utilization, according to the Care Coordination Levels shown in Exhibit M. The Contractor shall assign or arrange for Care Coordinators for each Member pursuant to an assessment of his or her needs, and assist the Member in achieving the best health, functional and self-management status possible.
- 3.7.2.12.1. The Care Coordinator shall follow up with the Member at least:
 - 3.7.2.12.1.1. Biweekly for any Member classified as Level 4
 - 3.7.2.12.1.2. Monthly for any Member classified as Level 3a or 3b
- 3.7.2.13. The Contractor shall provide support, via telephone, as requested by any Member of any classification level.
- 3.7.2.14. The Contractor shall provide the services to each Member, based on that Member's Care Coordination Levels, as described in Exhibit M.
- 3.7.2.15. The Contractor shall arrange for training on poverty-related issues, such as the Contractor's Bridges out of Poverty training, to all of its Care Coordinators within three months of that staff member's placement as a Care Coordinator. The Contractor shall provide updated training to all staff members as needed to address changes in the training, to address issues that arise in relation to poverty-related issues or as requested by the Department.
- 3.7.2.16. The Contractor shall seek consent from all Members, in the Contractor's Service Area, who seek care in the mental health system so that it may share this information with that Member's Care Coordinator.
- 3.7.3. Persons with Special Health Care Needs
 - 3.7.3.1. Continuation of Care for Persons with Special Health Care Needs
 - 3.7.3.1.1. The Contractor shall inform any new Member who is a Person with Special Health Care Needs as defined in 10 C.C.R. 2505-10, §8.205.9 that the Member may continue to receive Covered Services from the Member's current Provider for sixty (60) days from the date of Enrollment in the Contractor's Plan. The Member may only continue to receive Covered Services from the Member's current Provider if the Member is in an ongoing course of treatment with that Provider and the previous Provider agrees as specified in §25.5-5-406(1)(g), C.R.S.
 - 3.7.3.1.2. The Contractor shall inform a new Member with Special Health Care Needs that the Member may continue to receive Covered Services from ancillary Providers at the level of care received prior to Enrollment in the Contractor's Plan, for a period of seventy-five (75) days, as specified in §25.5-5-406(1)(g), C.R.S.
 - 3.7.3.1.3. The Contractor shall inform a new Member who is in her second or third trimester of pregnancy, that she may continue to see her current Provider until the completion of post-partum care directly related to the delivery, as specified in §25.5-5-406(1)(g), C.R.S.

- 3.7.3.2. The Contractor shall have sufficient experienced Providers with the ability to meet the unique needs of all Members who are Persons with Special Health Care Needs. If necessary primary or specialty care cannot be provided within the Contractor's network, the Contractor shall make arrangements for Members to access these Providers outside the network. The Contractor shall implement procedures to share the results of its identification and assessment of that Member's needs with other Providers serving the Member with Special Health Care Needs, in order to prevent duplication of those activities.
- 3.7.3.3. The Contractor shall implement mechanisms to assess each Member identified as a Person with Special Health Care Needs in order to identify any ongoing special conditions of the Member that require a course of treatment or regular care monitoring.
- 3.7.3.4. The Contractor shall allow Persons with Special Health Care Needs who use specialists frequently for their health care to maintain these types of specialists as PCMPs or be allowed direct access or a standing Referral to specialists for the needed care.
- 3.7.3.5. The Contractor shall establish and maintain procedures and policies to coordinate health care services for children with Special Health Care Needs with other agencies or entities such as those dealing with mental health and substance abuse, public health, transportation, home and community based care, Developmental Disabilities, local school districts, child welfare, IDEA programs, Title V, families, caregivers and advocates).
- 3.7.4. Accommodation of Members with Disabilities or Special Health Care Needs
 - 3.7.4.1. The Contractor shall promote accessibility and availability of Medically Necessary Covered Services, either directly or through subcontracts, to ensure that appropriate services and accommodations are made available to Members with a Disability or any Members with Special Health Care Needs. Covered Services for Members with Disabilities or Special Health Care Needs must be provided in such a manner that will promote independent living and Member participation in the community at large.
 - 3.7.4.2. To promote independent living, the Contractor shall:
 - 3.7.4.2.1. Respond within twenty-four (24) hours, after written or oral notice to the Contractor by the Member, the Member's parents, guardian or Designated Client Representative, to any diminishment of the capacity of a Member with a Disability to live independently.
 - 3.7.4.2.2. Deliver Covered Services that will restore the Member's ability to live independently as expeditiously as possible.
 - 3.7.4.3. The Contractor shall facilitate culturally and linguistically appropriate care, by implementing the following requirements:
 - 3.7.4.3.1. Establish and maintain policies to reach out to specific cultural and ethnic Members for prevention, health education and treatment for diseases prevalent in those groups.

- 3.7.4.3.2. Maintain policies to provide health care services that respect individual health care attitudes, beliefs, customs and practices of Members related to cultural affiliation.
- 3.7.4.3.3. Make a reasonable effort to identify Members whose cultural norms and practices may affect their access to health care. Such efforts may include inquiries conducted by the Contractor of the language proficiency of Members during the Contractor's orientation calls or being served by Participating Providers, or improving access to health care through community outreach and Contractor publications.
- 3.7.4.3.4. Develop and provide cultural competency training programs, as needed, to the network Providers and Contractor staff regarding all of the following:
 - 3.7.4.3.4.1. Health care attitudes, values, customs and beliefs that affect access to and benefit from health care services.
 - 3.7.4.3.4.2. The medical risks associated with the Client population's racial, ethical and socioeconomic conditions.
- 3.7.4.3.5. Make available written translation of Contractor materials, including Member handbook, correspondence and newsletters. Written Member information and correspondence shall be made available in languages spoken by prevalent non-English speaking Member populations within the Contractor's Service Area as directed by the Department or as required by 42 CFR 438.
- 3.7.4.3.6. Develop policies and procedures, as needed, on how the Contractor will respond to requests from Participating Providers for interpreter services by a Qualified Interpreter. This shall occur particularly in Service Areas where language may pose a barrier so that Participating Providers can:
 - 3.7.4.3.6.1. Conduct the appropriate assessment and treatment of non-English speaking Members, including Members with a Communication Disability.
 - 3.7.4.3.6.2. Promote accessibility and availability of Covered Services, at no cost to Members.
- 3.7.4.3.7. Develop policies and procedures on how the Contractor will respond to requests from Members for interpretive services by a Qualified Interpreter or publications in alternative formats.
- 3.7.4.3.8. Make a reasonable effort, when appropriate, to develop and implement a strategy to recruit and retain qualified, diverse and culturally competent clinical Providers that represent the racial and ethnic communities being served.
- 3.7.4.3.9. Provide access to interpretative services by a Qualified Interpreter for Members with a hearing impairment in such a way that it will promote accessibility and availability of Covered Services.
- 3.7.4.3.10. Develop and maintain written policies and procedures to ensure compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

- 3.7.4.3.11. Arrange for Covered Services to be provided through agreements with non-Participating Providers when the Contractor does not have the direct capacity to provide Covered Services in an appropriate manner, consistent with Independent Living, to Members with Disabilities.
- 3.7.4.3.12. Provide access to TDD or other equivalent methods for Members with a hearing impairment in such a way that it will promote accessibility and availability of Covered Services.
- 3.7.4.3.13. Make Member information available for Members with visual impairments, including, but not limited to, Braille, large print or audiotapes. For Members who cannot read, member information must be available on audiotape.

3.7.5. Preventative Health Services

- 3.7.5.1. The Contractor shall establish and maintain a comprehensive program of preventive health services for Members. The Contractor shall ensure that Members with a Disability have the same access to preventative health services as other Members. The program shall include written policies and procedures, involve Participating Providers and Members in their development and ongoing evaluation, and are a part of the Contractor's comprehensive quality assurance program as specified in Section 3.11 of this Statement of Work. The Contractor's program of preventive health services shall include, but is not limited to:
 - 3.7.5.1.1. Risk assessment by a Member's PCMP, or other qualified professionals specializing in risk prevention who are part of the Contractor's Participating Providers or under contract to provide such services, to identify Members with chronic or high risk illnesses, a Disability or the potential for such conditions.
 - 3.7.5.1.2. Health education and promotion of wellness programs, including the development of appropriate preventive services for Members with a Disability to prevent further deterioration. The Contractor shall also include the distribution of information to Members to encourage Member responsibility for following guidelines for preventive health. .
 - 3.7.5.1.3. Evaluation of the effectiveness of health preventive services, including monitoring and evaluation of the use of select preventive health services by at-risk Members.
 - 3.7.5.1.4. Procedures to identify priorities and develop guidelines for appropriate preventive services.
 - 3.7.5.1.5. Processes to inform and educate Participating Providers about preventive services, involve Participating Providers in the development of programs and evaluate the effectiveness of Participating Providers in providing such services.
- 3.7.5.2. The Contractor shall comply with all requirements of EPSDT rules at 42 C.F.R. §§441.50 through 441.61, as amended, to ensure that Members have access to EPSDT benefits including such benefits which are not Covered Services pursuant to this Contract. The Contractor shall meet all of the following EPSDT requirements as part of the preventative health services it offers:

- 3.7.5.2.1. The Contractor shall inform all Medicaid-eligible persons through age 20 that EPSDT services are available.
- 3.7.5.2.2. The Contractor shall provide or arrange for the provision of all of the required screening, diagnostic and treatment components according to state and federal EPSDT standards and periodicity schedule. The Contractor may offer additional preventive services beyond these required standards.
- 3.7.5.3. The Contractor shall comply with all requirements of the Alternative Benefits Plan (ABP) rules at §1937 of the Social Security Act.
- 3.7.5.3.1. The Contractor shall provide all benefits included in the Alternative Benefit Plan to all Expansion Members, including benefits which may not be Covered Services pursuant to this Contract.
- 3.7.5.3.2. Expansion Members shall receive the ABP which is the regular Medicaid benefit package plus the addition of Habilitative therapies.
- 3.7.6. Services Delivered Only to Members
 - 3.7.6.1. The Contractor shall ensure that Providers operating under the Contractor's Plan supply services only to Members. It is the responsibility of the Provider to verify that the individual receiving medical services is a Member on the date of service, whether the Contractor or the Department is responsible for reimbursement of the services provided and whether the Contractor has authorized a Referral or made special arrangements with a Provider, when appropriate. If a Provider has verified eligibility and enrollment as specified by the Department, the Department will reimburse the Contractor for the claim if the Department is responsible for the reimbursement of that claim.
 - 3.7.6.2. The Department will identify the eligible Expansion Members for the Contractor.
 - 3.7.6.2.1. The Contractor will advise all newly eligible Expansion Members enrolling in this plan of their benefit package, including regular Medicaid services as well as Habilitative therapy services.

3.8. PROVIDER SUPPORT

- 3.8.1. Administrative Support
 - 3.8.1.1. The Contractor shall make all of the Participating Providers in its network aware of Colorado Medicaid programs, policies and processes.
 - 3.8.1.1.1. This information shall include, but is not limited to, information regarding all of the following:
 - 3.8.1.1.1.1. Benefit packages and coverage policies.
 - 3.8.1.1.1.2. Prior authorization Referral requirements.
 - 3.8.1.1.1.3. Claims and billing procedures.
 - 3.8.1.1.1.4. Eligibility and enrollment processes.
 - 3.8.1.1.1.5. Other operational components of service delivery.

- 3.8.1.2. This information shall be delivered to providers during direct contact at meetings, forums, training sessions or seminars, or through any method of mailing, as defined in 10 C.C.R. 2505-10 §8.050.
- 3.8.1.3. The Contractor shall make informational and educational materials available to providers regarding the roles that the Department, the Contractor and other Department contractors and partners play in the Colorado Medicaid system. These other Department contractors and partners shall include, at a minimum all of the following:
 - 3.8.1.3.1. The Statewide Data Analytics Contractor (SDAC).
 - 3.8.1.3.2. The Department’s enrollment broker.
 - 3.8.1.3.3. The Department’s Medicaid fiscal agent.
 - 3.8.1.3.4. The Department’s utilization management contractor.
 - 3.8.1.3.5. The Department’s managed care ombudsman.
 - 3.8.1.3.6. The county departments of human and social services for the counties in the Contractor’s Region.
 - 3.8.1.3.7. The Community-Centered Boards and Single Entry Point agencies.
 - 3.8.1.3.8. Healthy Communities.
 - 3.8.1.3.9. The Department’s Dental Contractor.
- 3.8.1.4. The Contractor shall act as a liaison between the Department and its other contractors and partners and the providers. The Contractor shall assist providers in resolving barriers and problems related to the Colorado Medicaid systems, including, but not limited to all of the following:
 - 3.8.1.4.1. Issues relating to Medicaid provider enrollment.
 - 3.8.1.4.2. Prior authorization and Referral issues.
 - 3.8.1.4.3. Member eligibility and coverage policies.
 - 3.8.1.4.4. PCMP designation problems.
- 3.8.1.5. The Contractor shall submit written documentation of provider support activities to the Department for review. The Department may request changes to the provider support activities, and the Contractor shall make the changes and deliver the updated documents or plans to the Department.
 - 3.8.1.5.1. DELIVERABLE: Documentation of Provider Support Activities.
 - 3.8.1.5.2. DUE: Ten (10) days from the date the documents or plans are finalized for the original document, and ten (10) days from the request by the Department to make a change for updated documents.
- 3.8.2. Practice Support

- 3.8.2.1. The Contractor shall submit a Practice Support Plan, describing its annual activities, for Department review and approval. These practice support activities shall be directed at a majority of the PCMPs in the Contractor’s Service Area and may range from comprehensive guidance on practice redesign to providing assistance with practice redesign and performance-enhancing activities. These activities shall include at least one activity relating to each of the following topics and address how each activity achieves the goals of practice/medical home transformation, client/family centered care, and team based care:
 - 3.8.2.1.1. Operational practice support.
 - 3.8.2.1.2. Clinical tools.
 - 3.8.2.1.3. Client or Member materials.
 - 3.8.2.1.4. Inappropriate utilization of services and methods for diverting Members to the most appropriate care setting.
 - 3.8.2.1.5. Planned method of Medical Management Support and an assessment of the efficacy or success of the last method tried.
 - 3.8.2.1.5.1. DELIVERABLE: Practice Support Plan
 - 3.8.2.1.5.2. DUE: Annually, within the first three (3) months of the state fiscal year
- 3.8.2.2. The Contractor shall provide tools to the PCMPs that include the following:
 - 3.8.2.2.1. Clinical Tools:
 - 3.8.2.2.1.1. Clinical care guidelines and best practices
 - 3.8.2.2.1.2. Clinical screening tools, such as depression screening tools and substance use screening tools.
 - 3.8.2.2.1.3. Health and functioning questionnaires.
 - 3.8.2.2.1.4. Chronic care templates.
 - 3.8.2.2.1.5. Registries.
 - 3.8.2.2.2. Client Materials:
 - 3.8.2.2.2.1. Client reminders.
 - 3.8.2.2.2.2. Self-management tools.
 - 3.8.2.2.2.3. Educational materials about specific conditions.
 - 3.8.2.2.2.4. Client action plans.
 - 3.8.2.2.2.5. Behavioral health surveys and other self-screening tools.
 - 3.8.2.2.3. Operational Practice Support:
 - 3.8.2.2.3.1. Guidance and education on the principles of the Medical Home.
 - 3.8.2.2.3.2. Training on providing culturally competent care.
 - 3.8.2.2.3.3. Training to enhance the health care skills and knowledge of supporting staff.
 - 3.8.2.2.3.4. Guidelines for motivational interviewing.

- 3.8.2.2.3.5. Tools and resources for phone call and appointment tracking.
- 3.8.2.2.3.6. Tools and resources for tracking labs, Referrals and similar items.
- 3.8.2.2.3.7. Referral and transitions of care checklists.
- 3.8.2.2.3.8. Visit agendas or templates.
- 3.8.2.2.3.9. Standing pharmacy order templates.
- 3.8.2.2.4. Data, Reports and Other Resources:
 - 3.8.2.2.4.1. Expanded provider network directory.
 - 3.8.2.2.4.2. Comprehensive directory of community resources.
 - 3.8.2.2.4.3. Directory of other Department-sponsored resources, such as the managed care ombudsman and nurse advice line.
 - 3.8.2.2.4.4. Link from main ACC Program website to the Contractor's website of centrally located tools and resources.
- 3.8.2.3. Provider Support Accessibility
 - 3.8.2.3.1. The Contractor shall have an internet-accessible website that contains, at a minimum, all of the following:
 - 3.8.2.3.1.1. General information about the ACC Program, the Contractor entity, the Contractor's role and purpose and the principles of a Medical Home.
 - 3.8.2.3.1.2. A network directory listing providers and PCMPs with whom the Contractor has a contract, their contact information and provider characteristics such as gender, languages spoken, whether they are currently accepting new Medicaid clients and links to the provider's website if available.
 - 3.8.2.3.1.3. A provider page or section that contains a description of the support the Contractor offers to providers, an online library of available tools, screenings, clinical guidelines, practice improvement activities, templates, trainings and any other resources the Contractor has compiled.
 - 3.8.2.3.1.4. A listing of immediately available resources to guide providers and their Members to needed community-based services, such as child care, food assistance, services supporting elders, housing, utility assistance and other non-medical supports.
 - 3.8.2.4. The Contractor shall use a health information exchange, such as Quality Health Network, to facilitate improved clinical information sharing, where such services are available, and only to the extent that data is accessible under the terms of any applicable HIPAA Business Associate agreements.
 - 3.8.2.5. The Contractor shall provide interpreter services for all interactions with Members or Clients when there is no bilingual or multilingual Member of the Contractor available who speaks a language understood by a Member.

- 3.8.2.5.1. The Contractor may provide interpreter services for any PCMP in the Contractor's Region or any other provider with whom the Contractor has an agreement that the provider needs to interact with Members.

3.9. COMPLIANCE AND MONITORING

3.9.1. Utilization Management

- 3.9.1.1. The Contractor shall follow CMS regulations regarding Utilization Management in 42 C.F.R. Section 438, *et seq.*
- 3.9.1.2. The Contractor shall have a mechanism in effect to ensure consistent application of review criteria for authorization decisions and consultation with the requesting Provider when appropriate. The Contractor shall notify the requesting provider of any decision to deny a Service Authorization request or to authorize a service in an amount, duration or scope that is less than requested. The notice to the Provider may be oral or in writing.
- 3.9.1.3. The Contractor shall provide information to Members and Participating Providers, in appropriate formats, about how the Contractor's Utilization Management program functions and is utilized to determine the Medical Necessity of Covered Services. This information shall include appropriate points of contact with the program, contact persons or numbers for information or questions, and information about how to initiate appeals related to Utilization Management determinations.
 - 3.9.1.3.1. The Contractor shall provide information to Members, at the time of the Member's Enrollment, which includes, but is not limited to, the purpose of the Contractor's Utilization Management program and how the program works.
 - 3.9.1.3.2. The Contractor shall provide information to Participating Providers, at the time an agreement with that Provider is executed, that includes, but is not limited to, necessary information and guidelines to enable the Provider to understand and participate appropriately in the Utilization Management program.
- 3.9.1.4. The Contractor shall maintain data systems sufficient to support Utilization Management review program activities and to generate management reports that enable the Contractor to effectively monitor and manage Covered Services, grievances and appeals and Disenrollments for reasons other than loss of Medicaid eligibility.
- 3.9.1.5. The Contractor shall ensure that any decision to deny a Service Authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease.
- 3.9.1.6. Utilization Management review shall be conducted under the direction of a qualified clinician.
- 3.9.2. Compliance Monitoring

- 3.9.2.1. The Contractor shall comply with requirements and limitations regarding abortions, hysterectomies and surgical sterilizations and shall maintain certifications and documentation specified in 42 C.F.R. §441, Subparts E and F. The certifications and documentations, as well as any summary reports, shall be available to the Department within ten (10) business days of the Department's request.
- 3.9.2.2. Upon the Department's request, the Contractor shall submit to the Department any appropriate information necessary for the Department to issue a Certificate of Creditable Coverage on behalf of a Member whose eligibility for Medicaid has ended as the Department is required to do under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. § 1320d – 1320d-8, and its implementing regulations.
- 3.9.3. Other Monitoring Activities
 - 3.9.3.1. The Contractor shall participate in and respond to other Department compliance monitoring activities, including but not limited to:
 - 3.9.3.1.1. Encounter Claims Data analysis and Encounter Claims Data validation (the comparison of Encounter Claims Data with Medical Records).
 - 3.9.3.1.2. Appeals analysis to identify trends in the Medicaid program and among managed care organizations.
 - 3.9.3.1.3. Other reviews determined by the Department.
 - 3.9.3.2. The Department may determine Contractor compliance with individual requirements under this Contract based upon satisfactory review by recognized state agencies or private accreditation organizations.
- 3.9.4. Inspection, Monitoring and Site Reviews
 - 3.9.4.1. Site Reviews
 - 3.9.4.1.1. The Department may conduct Site Reviews of the Contractor's, Subcontractors' or Participating Providers' locations on an annual basis or more frequently if the Department determines more frequent reviews to be necessary in its sole discretion. The Department will conduct these Site Reviews for the purpose of determining compliance by the Contractor with applicable Department regulations and the requirements of this Contract. In the event that right of access is requested under this section, the Contractor and/or its Subcontractors or Participating Providers shall, provide and make available staff to assist in the audit or inspection effort. They shall provide adequate space on the premises to reasonably accommodate Department, state or federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner that will not unduly interfere with the performance of the Contractor's, Subcontractor's or Participating Providers' provision of care.
 - 3.9.4.1.2. An emergency or unannounced review may be required in instances where Member safety, quality of medical care, potential fraud or financial viability is at risk. The Department may determine when an emergency review is required in its sole discretion.

- 3.9.4.1.3. For non-emergency Site Reviews, the Contractor shall participate in the preview of the monitoring instrument to be used as part of the assessment and shall be contacted for mutually agreed upon dates for a Site Review. Final notice of the Site Review schedule and a copy of the monitoring instrument will be mailed to the Contractor at least three (3) weeks prior to the visit. The Contractor shall submit copies of policies, procedures, manuals, handbooks, reports, and other requested materials to facilitate the Department's Desk Audit prior to the Site Review. The Contractor shall have a minimum of thirty (30) days to submit the required materials for non-emergency reviews.
- 3.9.4.1.4. The Contractor shall make available, to the Department and its agents for Site Review, all records and documents related to the execution of this Contract, either on a scheduled basis as noted elsewhere in this section, or immediately on an emergency basis. Delays in the availability of such documents and records may subject the Contractor to remedial actions, as specified in this Contract. These records and documents shall be maintained according to statutory or general accounting principles and shall be easily separable from other Contractor records and documents.
- 3.9.4.1.5. A written report of the site visit will be transmitted to the Contractor within forty five (45) days of the Site Review. The Contractor shall be allowed thirty (30) days to review the preliminary report and respond to the findings. The final report will indicate areas of strength, suggestions for improvement, and required actions. A copy of the Site Review report and Contractor response will be transmitted to the Colorado Department of Regulatory Agencies, Division of Insurance.
- 3.9.4.1.6. The Contractor shall respond to any required actions, if necessary, with a corrective action plan within thirty (30) days of the final written report, specifying the action to be taken to remedy any deficiencies noted by the Department or its agents and time frames to implement these remedies. The corrective action plan is subject to approval by the Department. The Department will monitor progress on the corrective action plan until the Contractor is found to be in complete compliance. Department will notify the Contractor in writing when the corrective actions have been completed, accepted and the Contractor is considered to be in compliance with Department regulations and this Contract.
- 3.9.4.1.7. The Department may extend the time frame for corrective action in its sole discretion. The Department may also reduce the time frame for corrective action if delivery of Covered Services for Members is adversely affected or if the time reduction is in the best interests of Clients or Members, as determined by the Department. For corrective action plans affecting the provision of Covered Services to Members, the Contractor shall ensure that Covered Services are provided to Members during all corrective action periods.
- 3.9.4.1.8. Any data submitted by the Contractor to the Department or its agents after the last site visit day will not be accepted towards compliance with the visit in the written report. This data will only apply toward the corrective action plan.

- 3.9.4.1.9. The Site Review may include reviews of a sample of Participating Providers to ensure that Providers have been educated and monitored by the Contractor about the requirements under this Contract.
- 3.9.5. Contractor Review of Studies, Inspections, Site Reviews and Audits
- 3.9.5.1. The Department shall submit the results of any studies, inspections, Site Reviews or audits of the Contractor, or its Subcontractors or Participating Providers, to the Contractor for review. The Contractor shall have ten (10) business days to review the results of the study or audit prior to the Department releasing those results to the public. The Department may consider the Contractor's review or comments before releasing those results to the public.
- 3.9.6. Encounter Claims Data Provisions
- 3.9.6.1. The Contractor shall certify all Encounter Claims Data submitted is accurate, complete and truthful based on the Contractor's best knowledge, information and belief. This certification shall be signed by either the Chief Executive Officer or the Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to, the Chief Executive Officer or Chief Financial Officer.
- 3.9.6.2. Contractor shall submit all Encounter Claims Data electronically, following the Colorado Medical Assistance Program policy rules found in Volume VIII, the Medical Assistance Manual of the Colorado Department of Health Care Policy and Financing (Program Rules and Regulations) or in the Colorado Code of Regulations (10 CCR 2505-10). Encounter data shall be submitted in the current ANSI ASC X12N 837 version directly to the Department's fiscal agent using the Department's data transfer protocol. Contractor shall follow the guidelines for data submission set forth in the 837 X12N Companion Guide Specifications provided by the Department available at: <http://www.colorado.gov/>.
- 3.9.6.2.1. 837-format encounter claims, reflecting all medical, facility and supplier claims paid and/or adjusted by the Contractor, shall be submitted via a regular monthly batch process to the MMIS as follows:
- 3.9.6.2.1.1. All encounter claims shall be submitted in accordance with applicable HIPAA transaction guides posted at <http://www.wpc-edi.com>.
- 3.9.6.2.1.2. For Hospital, Ambulatory Surgery Center and Home Health Encounter Claims:
- 3.9.6.2.1.2.1. Both inpatient and outpatient Hospital and home health encounter claims include paid services provided by a Hospital, ambulatory surgery center or home health agency. These encounter claims shall contain revenue and procedure codes, as appropriate. One encounter claim shall be submitted for each hospitalization, outpatient visit or outpatient surgery. Multiple home health visits may be on one home health encounter claim. The encounter claim shall represent all services delivered to the Member during the billing episode billed.

- 3.9.6.2.1.2.2. Hospital, ambulatory surgery center and home health encounter claims shall be submitted using the ANSI 837I, Health Care Claim Institutional format.
- 3.9.6.2.1.2.3. Certain services, such as an infusion during home health, may be billed on an ANSI 837P, Health Care Claim Professional format rather than an ANSI 837I, Health Care Claim Institutional format. Such services may be submitted in the format received by the Contractor from the Provider.
- 3.9.6.2.1.3. For Pharmacy Encounter Claims:
 - 3.9.6.2.1.3.1. Pharmacy encounter claims refer to all paid pharmaceutical prescriptions. Paid pharmaceutical prescriptions shall not include denied claims.
 - 3.9.6.2.1.3.2. A pharmacy encounter Claim is a single prescription. If a single Member has multiple prescriptions filled from a single Provider a separate Pharmacy Encounter Claim should be submitted for each prescription.
 - 3.9.6.2.1.3.3. All pharmacy encounters claims shall be submitted using the HIPAA compliant format approved by the National Council for Prescription Drug Program (NCPDP).
 - 3.9.6.2.1.4. For Medical Encounter Claims:
 - 3.9.6.2.1.4.1. Medical encounter claims include paid services delivered by any Provider. These claims may include, but are not limited to services delivered by medical groups, practices, clinics, Physicians, mid-level practitioners, medical equipment suppliers, family planning clinics, independent laboratories, optometrists, podiatrists, FQHCs, freestanding rehabilitation centers, or any other Providers.
 - 3.9.6.2.1.4.2. When a Member receives services from multiple Providers in the same day, Contractor shall submit separate encounter claims for each visit for each Provider.
 - 3.9.6.2.1.4.3. Medical encounters shall be submitted using the ANSI 837P, Health Care Claim professional format. The Contractor shall submit all claims in compliance with the Provider Billing Manual Guidelines, available at <http://www.colorado.gov/hcpf>.
 - 3.9.6.2.1.4.4. The Contractor shall comply with the process for family planning documentation methodology and reporting, shown in Exhibit L, Family Planning Documentation Methodology and Reporting.
 - 3.9.6.2.1.5. Each 837-format claim submitted shall identify provider types as follows:

- 3.9.6.2.1.5.1. The Billing Provider ID shall be the Medical Assistance Program Provider Pseudo ID assigned by the Department to the Contractor for each provider type that is billed using the 837P format. The Billing Provider ID shall be the Medical Assistance Program Provider Medicaid ID assigned by the Department for each provider type that is billed using the 837I format.
- 3.9.6.2.1.5.2. Rendering (and attending) Provider ID shall be Managed Care Plan's Medicaid ID assigned to the Contractor by the Department.
- 3.9.6.2.1.5.3. The Pay-to-Provider will not be submitted on Encounter claims.
- 3.9.6.2.2. For 837-format submissions, Contractor shall submit actual claim paid amounts
- 3.9.6.2.3. Contractor shall use the enrollment reports to identify and confirm membership and provide a definitive basis for payment adjustment and reconciliation. Such data transmissions and enrollment reports shall include:
 - 3.9.6.2.3.1. Medicaid Management Information System (MMIS) reports, which verify Medicaid eligibility
 - 3.9.6.2.3.2. Daily generated Prepaid Health Plan (PHP) Manually Override of enrollment data changes (R0268)
 - 3.9.6.2.3.3. Daily generated PHP Disenrollment Report (R0305)
 - 3.9.6.2.3.4. Monthly generated PHP Disenrollment Report (M0305)
 - 3.9.6.2.3.5. Monthly generated PHP Enrollment Change Report (R0310)
 - 3.9.6.2.3.6. Monthly generated PHP Current Membership Report (R0315)
 - 3.9.6.2.3.7. Daily generated PHP New Membership Report (R0325)
 - 3.9.6.2.3.8. Monthly generated PHP New Membership Report (M0325)
 - 3.9.6.2.3.9. Monthly generated PHP Capitation Summary Report (R0360)
 - 3.9.6.2.3.10. HIPAA compliant X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transaction
 - 3.9.6.2.3.11. HIPAA compliant X12N 834 Health Care Enrollment and Maintenance standard transaction
- 3.9.6.2.4. Contractor, on a quarterly basis, shall electronically submit a flat file table that contains all encounters for that SFY year, with one record per encounter, which the Contractor shall certify is accurate, complete and truthful based on the Contractor's best knowledge, information and belief. This certification shall be signed by either the Chief Executive Officer or the Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to, the Chief Executive Officer or Chief Financial Officer.
- 3.9.6.2.5. Flat file tables shall be submitted per the specifications listed in Exhibit D.

3.9.7. Cybersecurity

3.9.7.1. The Contractor shall ensure that all of its information technology systems and websites are operated and maintained in compliance with all state and federal statutes, regulations and rules and all State of Colorado Cyber Security Policies, in accordance with a reasonable implementation plan.

3.9.8. SDAC Access Compliance

3.9.8.1. The Contractor shall comply with the Department's SDAC Web Portal access policy.

3.10. SERIOUS REPORTABLE AND NEVER EVENTS

3.10.1. The Contractor shall track all Serious Reportable Events as described in Exhibit J, Serious Reportable Events or Never Events and any service with the Present on Admission (POA) indicator at the time of a hospital admission.

3.10.1.1. The Contractor or rendering Provider shall not bill the Client or Medicaid for POA related services.

3.10.1.2. Contractor shall not reimburse any Provider for the additional costs resulting from the hospital acquired conditions and Serious Reportable Events in Exhibit J.

3.11. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

3.11.1. The Contractor shall maintain an internal quality assessment and performance improvement program that complies with 42 C.F.R. §438.200 for all Covered Services.

3.11.2. The scope of the Contractor's internal quality assessment and performance improvement program shall be comprehensive and shall include, but not be limited to:

3.11.2.1. Practice Guidelines.

3.11.2.1.1. The Contractor shall develop practice guidelines for the following:

3.11.2.1.1.1. Perinatal, prenatal and postpartum care for women;

3.11.2.1.1.2. Conditions related to Persons with a Disability or Special Health Care Needs; and

3.11.2.1.1.3. Well child care.

3.11.2.1.2. The Contractor shall ensure that practice guidelines comply with the following requirements:

3.11.2.1.2.1. The guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field.

3.11.2.1.2.2. The guidelines consider the needs of the Member.

3.11.2.1.2.3. They are adopted in consultation with Participating Providers.

3.11.2.1.2.4. The Contractor reviews and updates the guidelines at least annually.

3.11.2.1.3. The Contractor shall disseminate the practice guidelines to all affected Providers and, upon request, to Members, Clients, the Department, other non-Members and the public at no cost.

- 3.11.2.1.4. The Contractor shall ensure that decisions regarding Utilization Management, Member education, Covered Services and other areas to which the guidelines apply are consistent with the guidelines to the extent that services set forth in the guidelines are Covered Services hereunder.
- 3.11.2.2. Performance Improvement Projects (PIPs)
- 3.11.2.2.1. The Contractor shall conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.
- 3.11.2.2.2. Performance improvement projects shall follow requirements as outlined in External Quality Review Organization (EQRO) Protocol Validating Performance Improvement Projects and as directed by the Department.
- 3.11.2.2.3. The Contractor shall conduct performance improvement projects on topics selected by the CMS when the Department is directed by CMS to focus on a particular topic.
- 3.11.2.2.4. In addition to the standard PIP, the Contractor shall engage in a new PIP designed to demonstrate the uniqueness and value of this Contract as determined by the Department.
- 3.11.2.2.5. The Contractor shall complete performance improvement projects in a reasonable time period in order to facilitate the integration of project findings and information into the overall quality assessment and improvement program and to produce new information on quality of care each year.
- 3.11.2.2.6. The Contractor shall participate in an annual PIP learning collaborative hosted by the Department.
- 3.11.2.2.6.1. DELIVERABLE: Performance Improvement Projects.
- 3.11.2.2.6.2. DUE: To be determined by the Department.
- 3.11.2.3. Performance Measurement Data
- 3.11.2.3.1. Healthcare Effectiveness Data and Information Set (HEDIS)
- 3.11.2.3.1.1. The Contractor shall calculate and submit specified HEDIS measures. The Department will collaborate with the Contractor's quality improvement committee to designate the required measures.
- 3.11.2.3.1.2. The Contractor shall analyze and respond to results indicated in the HEDIS measures.
- 3.11.2.3.1.3. The Contractor shall contract with a NCQA (National Committee for Quality Assurance) certified individual entity to perform an external audit of the HEDIS measures according to HEDIS protocols.
- 3.11.2.3.1.4. Any failed audit that nullifies more than three (3) required HEDIS measures is considered non-compliant with this requirement.
- 3.11.2.3.2. Mandatory Federal Performance Measurements

- 3.11.2.3.2.1. The Contractor shall calculate additional performance measures when they are developed and required by CMS.
- 3.11.2.4. Member Satisfaction
- 3.11.2.4.1. The Contractor shall monitor Member perceptions of accessibility and adequacy of services provided by the Contractor. The Contractor shall use tools to measure these Member perception and those tools shall include, at a minimum, the use of Member surveys, anecdotal information, grievance and appeals data and Enrollment and Disenrollment information.
- 3.11.2.4.2. The Contractor shall fund an annual Member satisfaction survey, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) with all Department directed supplemental questions, surveys and populations, administered by a certified survey vendor according to appropriate survey protocols. In lieu of a satisfaction survey conducted by an external entity, the Department, at the Department's discretion, may conduct the survey. The Contractor shall deliver any surveys to the Department for review and shall not administer any survey until it has received the Department's approval of that survey. The Contractor shall report to the Department or the Department's designated contractor results and all raw data of internal satisfaction surveys of Members designed to identify areas of satisfaction and dissatisfaction by June 30th of each fiscal year.
- 3.11.2.4.3. The Contractor shall develop a corrective action plan when Members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected or when a serious complaint is reported.
- 3.11.2.4.4. The Contractor shall implement and maintain a mechanism to assess the quality and appropriateness of care for Persons with Special Health Care Needs.
- 3.11.2.5. Mechanisms to Detect Over and Under Utilization
- 3.11.2.5.1. The Contractor shall implement and maintain a mechanism to detect overutilization and underutilization of services and to assess the quality and appropriateness of care furnished to enrollees with special health care needs. These mechanisms may incorporate those developed for the Contractor's Utilization Management program.
- 3.11.2.6. Quality of Care Concerns
- 3.11.2.6.1. The Contractor shall investigate any alleged quality of care concerns.
- 3.11.2.6.2. In response to a request from the Department in relation to any quality of care concern, the Contractor shall submit a letter to the Department that includes a brief but clear description of the issue, the efforts that the Contractor took to investigate the issue and the outcome of the review as determined by the Contractor. The outcome shall include whether or not the issue was found to be a quality of care issue and what action the Contractor intends to take with the Provider or Providers involved. The letter shall not include any names of the persons conducting the investigation or participating in any peer review process.

- 3.11.2.6.2.1. The letter shall be delivered to the Department within ten (10) business days of the Department's request. Upon request, the Department may allow additional time to investigate and report. If the Contractor refers the matter to a peer review process, it shall inform the Department of that referral.
- 3.11.2.6.2.2. Notwithstanding any other provision of this Contract, the Contractor may not disclose any information that is confidential by law. After the letter is received by the Department, if there is a request for public disclosure pursuant to the Colorado Open Records Act at Section 24-72-203, C.R.S., the Department will assert any applicable exemptions and, if none apply, will petition the court pursuant to Section 24-72-204(6)(a), C.R.S. to prohibit disclosure.
- 3.11.2.7. Quality Improvement Committee
- 3.11.2.7.1. The Contractor shall participate in the Department's Medical Quality Improvement Committee (MQuIC) to provide input and feedback regarding quality improvement priorities, performance improvement topics and measurements and specifics of reporting formats and time frames, and other collaborative projects.
- 3.11.2.8. Performance Improvement Advisory Committee (PIAC)
- 3.11.2.8.1. The Contractor shall create a Performance Improvement Advisory Committee to provide input into the Contractor's implementation of the ACC Program and the Contractor's own performance improvement program. The Performance Improvement Advisory Committee shall:
- 3.11.2.8.1.1. Be directed and chaired by one of Contractor's Key Personnel.
- 3.11.2.8.1.2. Have a formal, documented membership and governance structure.
- 3.11.2.8.1.3. Have a diverse membership, representative of the Contractor's Region, which includes members representing at least the following:
- 3.11.2.8.1.4. Members.
- 3.11.2.8.1.4.1. Member's families.
- 3.11.2.8.1.5. Advocacy groups and organizations.
- 3.11.2.8.1.6. The PCMP network.
- 3.11.2.8.1.7. Other Medicaid providers.
- 3.11.2.8.1.8. The Behavioral Health community.
- 3.11.2.8.1.9. Charitable, faith-based or service organizations within the community.
- 3.11.2.8.1.10. Hold regularly scheduled meetings, no less often than on a quarterly basis.
- 3.11.2.8.1.11. Open all scheduled meetings to the public.
- 3.11.2.8.1.12. Post the minutes of each meeting on the Contractor's website within ten (10) days of each meeting.

- 3.11.2.8.1.12.1. DELIVERABLE: Posted meeting minutes, meeting information for upcoming meetings, and the name and direct phone number of a contact person on the Contractor’s website.
- 3.11.2.8.1.12.2. DUE: Ten (10) business days from the date of the meeting.
- 3.11.2.9. The ACC Program Improvement Advisory Committee
 - 3.11.2.9.1. The Contractor shall provide one representative to serve as a member of the Department’s ACC Program Improvement Advisory Committee. This individual shall be the Contractor’s representative to the ACC Program Improvement Advisory Committee. The ACC Program Improvement Advisory Committee will solicit input and feedback on the ACC Payment Reform Pilot Program (this Contract) as one area of the ACC program.
- 3.11.2.10. Program Impact Analysis
 - 3.11.2.10.1. The Contractor shall maintain a process for evaluating the impact and effectiveness of the quality assessment and improvement program on at least an annual basis.
 - 3.11.2.10.2. Upon request, this information shall be made available to Providers and Members at no cost.
 - 3.11.2.10.2.1. DELIVERABLE: Program Impact Analysis
 - 3.11.2.10.2.2. DUE: Annually, by the last business day in September
- 3.11.2.11. Quality Improvement Plan
 - 3.11.2.11.1. The Contractor shall provide a quality improvement plan to the Department. The plan shall delineate current and future quality assessment and performance improvement activities. The plan shall integrate findings and opportunities for improvement identified in HEDIS measurements, member satisfaction surveys, performance improvement projects and other monitoring and quality activities as required by the Department. The plan is subject to the Department’s approval.
 - 3.11.2.11.1.1. DELIVERABLE: Quality Improvement Plan
 - 3.11.2.11.1.2. DUE: Annually, by the last business day in September
- 3.11.2.12. External Review
 - 3.11.2.12.1. The Contractor shall participate in the annual external independent review of quality outcomes, timeliness of, and access to the services covered under this Contract. The external review may include but not be limited to all or any of the following:
 - 3.11.2.12.1.1. Medical Record review.
 - 3.11.2.12.1.2. Performance improvement projects and studies.
 - 3.11.2.12.1.3. Surveys.
 - 3.11.2.12.1.4. Calculation and audit of quality and utilization indicators.

- 3.11.2.12.1.5. Administrative data analyses.
- 3.11.2.12.1.6. Review of individual cases.
- 3.11.2.12.2. For external review activities involving Medical Record abstraction, the Contractor shall be responsible for obtaining copies of the Medical Records from the sites in which the services reflected in the encounter occurred.
- 3.11.2.12.3. The Contractor shall participate in the development and design of any external independent review studies to assess and assure quality of care. The final study specifications shall be at the discretion of the Department.
- 3.11.2.13. Health Information Systems
 - 3.11.2.13.1. The Contractor shall maintain a health information system that collects, analyzes, integrates and reports data. The system shall provide information on areas including, but not limited to, utilization, grievances and appeals, encounters and Disenrollment.
 - 3.11.2.13.2. The Contractor shall collect data on Member and Provider characteristics and on services furnished to Members.
 - 3.11.2.13.3. The Contractor shall make all collected data available to the Department and to CMS upon request.
 - 3.11.2.13.4. The Contractor shall ensure that the data received from providers is accurate and complete, by:
 - 3.11.2.13.4.1. Verifying the accuracy and timeliness of reported data;
 - 3.11.2.13.4.2. Screening the data for completeness; and
 - 3.11.2.13.4.3. Collecting service information in standardized formats to the extent feasible and appropriate.
 - 3.11.2.13.5. The Contractor shall make timely, good faith and reasonable efforts to work with the Department and any of the Department's contractors, as directed by the Department, in order to promote efficiency and the health and welfare of Clients and meet the requirements and timelines set forth in the Health Information Technology for Economic and Clinical Health (HITECH) provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) and subsequent rules.

SECTION 4.0 MEMBER AND PROVIDER ISSUES

4.1. MEMBER ISSUES

- 4.1.1. Member Services, Rights and Responsibilities
 - 4.1.1.1. The Contractor shall establish and maintain written policies and procedures for treating all Members in a manner that is consistent with all the following rights, and shall follow all such policies and procedures:
 - 4.1.1.1.1. Contractor shall comply with any applicable federal and state laws that pertain to Member rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to Members.

- 4.1.1.1.2. Each Member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
- 4.1.1.1.3. Each Member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.
- 4.1.1.1.4. Each Member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
- 4.1.1.1.5. Each Member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- 4.1.1.1.6. Each Member is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR Part 164.
- 4.1.1.1.7. Each Member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Contractor, Subcontractors, providers or the Department treats the Member.
- 4.1.1.1.8. To receive, from the Provider and at the times specified in 42 C.F.R. Section 489.102, information concerning the implementation of Advance Directives, including a clear and precise statement of limitation if the Provider cannot implement an Advance Directive on the basis of conscience. The information shall include the Member's rights under this Contract, the Contractor's policies regarding the implementation of those rights and a statement regarding the fact that complaints concerning noncompliance with the Advance Directive requirements may be filed with the State Department of Public Health and Environment. Such information shall be provided in writing or an alternate format appropriate for the Member. Changes in state law shall be reflected in the Contractor's written material no later than ninety (90) days after the effective date of the change.
- 4.1.1.2. Member Responsibilities
 - 4.1.1.2.1. The Contractor shall establish and maintain written requirements for Member participation and the responsibilities of Members in receiving Covered Services that are consistent with all responsibilities enumerated in 10 C.C.R. 2505-10, §8.205.2 and any amendments thereto.
- 4.1.1.3. Written Policies, Procedures and Information Relating to Members
 - 4.1.1.3.1. The Contractor shall establish and maintain written policies and procedures regarding the rights and responsibilities of Members that incorporate the rights and responsibilities identified by the Department in this Contract. These policies and procedures shall include the components described in this section and address the elements listed in Exhibit K, Member Information.

- 4.1.1.3.2. The Contractor shall provide to all Members, including new Members, a Member handbook. This Member handbook shall include general information about services offered by the Contractor and complete statements concerning Member rights and responsibilities as listed in this section within a reasonable time after the Contractor is notified of the Enrollment. The Member handbook shall include all of the minimum requirements listed in Exhibit K. The Department may review the Member handbook upon request and the Contractor shall make any changes to the Member handbook directed by the Department within forty-five (45) days of the Department's request.
- 4.1.1.3.3. Written information provided to Members shall be written, to the extent possible, at the sixth (6th) grade level, unless otherwise directed by the Department. All materials shall be written in English and Spanish, or any other prevalent language, as directed by the Department or as required by 42 CFR 438. The Contractor shall notify all Members and potential Members of the availability of alternate formats for the information, as required by 42 CFR 438.10, and how to access such information.
- 4.1.1.3.4. The Contractor shall include in its Member handbook and Marketing Materials a provision clearly stating that Enrollment in the Contractor's Plan is voluntary. Contractor shall include information in its Member handbook about how to request disenrollment.
- 4.1.1.3.5. The Contractor may provide Members with similar information, in the same manner as that information is provided to private or commercial enrollees, but shall also provide Members with additional information as appropriate to promote compliance with this Contract.
- 4.1.1.3.6. The Contractor shall provide periodic updates to the Member handbook when needed to explain changes to the above policies. Prior to printing, the Contractor shall submit the updates to the Department for review and approval, at least thirty (30) days prior to the targeted printing date.
- 4.1.1.3.7. The Contractor shall provide a copy of the policies on Members' rights and responsibilities to all Participating Providers and ensure that Participating Providers are aware of information being provided to Members.
- 4.1.1.3.8. The Contractor and its representatives shall not knowingly provide untrue or misleading information, as defined at §10-16-413 (1)(a)-(c), C.R.S., regarding the Contractor's Plan or Medicaid eligibility, to Clients or Members.
- 4.1.1.4. Notices of Changes, Information and Actions
 - 4.1.1.4.1. The Contractor shall notify all Members of their right to request and obtain the information listed in Exhibit G, at least once per year. The Contractor shall also notify Members of any significant changes in the following information at least thirty (30) days prior to the effective date of the change. Significant changes include, but are not limited to:
 - 4.1.1.4.1.1. The amount, duration and scope of Covered Services available.

- 4.1.1.4.1.2. Procedures for obtaining Covered Services, including authorization requirements.
- 4.1.1.4.1.3. The extent to which, and how, Members may obtain benefits, including family planning services, from out-of-network Providers.
- 4.1.1.4.1.4. The extent to which, and how, after-hours and Emergency Services are provided including:
 - 4.1.1.4.1.4.1. What constitutes an Emergency Medical Condition, Emergency Services and Post-Stabilization Care Services.
 - 4.1.1.4.1.4.2. The fact that prior authorization is not required for Emergency Services.
 - 4.1.1.4.1.4.3. The process and procedures for obtaining Emergency Services, including use of the 911 telephone system or its local equivalent.
 - 4.1.1.4.1.4.4. The locations of any emergency settings and other locations at which Providers and Hospitals furnish Emergency Services and Post-Stabilization Care Services covered under the Contract.
 - 4.1.1.4.1.4.5. The fact that, subject to the provisions of this section, the Member has the right to use any Hospital or other setting for Emergency Services.
- 4.1.1.4.1.5. Policy on Referrals.
- 4.1.1.4.1.6. Any cost sharing or co-pays that the Member is responsible for in relation to the receipt of a Covered service.
 - 4.1.1.4.1.6.1. All cost sharing and co-pays shall be implemented and imposed in accordance with 42 CFR 447.50 through 42 CFR 447.60.
- 4.1.1.4.1.7. How and where to access Wrap Around Benefits, including any cost sharing and how transportation is provided. For a counseling or Referral service that the Contractor does not cover because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service.
- 4.1.1.4.2. The Contractor shall provide written notice to all Members affected by an adverse action within the timeframes described in this section.
 - 4.1.1.4.2.1. All notices of adverse action shall contain, at a minimum, all of the following:
 - 4.1.1.4.2.1.1. The action the Contractor or its Subcontractor has taken or intends to take.
 - 4.1.1.4.2.1.2. The reasons for the action.
 - 4.1.1.4.2.1.3. The Member's or the Provider's right to file an appeal.
 - 4.1.1.4.2.1.4. The Member's right to request a State Fair Hearing.
 - 4.1.1.4.2.1.5. Procedures for exercising Member's rights to appeal or grieve.
 - 4.1.1.4.2.1.6. Circumstances under which expedited resolution is available and how to request it.

- 4.1.1.4.2.1.7. The Member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.
- 4.1.1.4.3. The Contractor shall notify all affected Members, whenever the Contractor terminates, suspends or reduces any previously authorized Covered Service. The Contractor shall provide this notice at least ten (10) days prior to the termination, suspension or reduction, except:
 - 4.1.1.4.3.1. The period of advanced notice is shortened to five (5) days if probable recipient fraud has been verified.
 - 4.1.1.4.3.2. The notice shall be provided by the date of the termination, suspension or reduction for the following:
 - 4.1.1.4.3.2.1. The death of a Member.
 - 4.1.1.4.3.2.2. A signed written Member statement requesting service termination or giving information requiring termination or reduction of services, where the Member understands that this will be the result of supplying that information.
 - 4.1.1.4.3.2.3. The Member's admission to an institution where the Member is ineligible for further services.
 - 4.1.1.4.3.2.4. The Member's address is unknown and mail directed to him has no forwarding address.
 - 4.1.1.4.3.2.5. The Member has been accepted for Medicaid services by another local jurisdiction.
 - 4.1.1.4.3.2.6. The Member's physician prescribes the change in the level of medical care.
 - 4.1.1.4.3.2.7. An adverse determination is made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989.
 - 4.1.1.4.3.2.8. For adverse actions relating to a nursing facility transfer, the safety or health of individuals in the nursing facility where the Member is a resident would be endangered, the resident Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident Member's urgent medical needs, or a resident Member has not resided in the nursing facility for thirty (30) days.
- 4.1.1.4.4. The Contractor shall notify a Member of a denial of any payment for a claim made by that Member on the date of the denial, as required by 42 CFR 438.404.
- 4.1.1.4.5. The Contractor shall notify the Member of any standard Service Authorization denial within ten (10) days of the Member's request for the service.

- 4.1.1.4.5.1. In the event that the Department approves the Contractor's justifiable need for additional information in relation to a Service Authorization, or at the request of the Member or the member's provider, the due date for the notification may be extended for an additional fourteen (14) days.
- 4.1.1.4.5.2. If a Provider or the Contractor determine that the standard Service Authorization timeline would jeopardize a Member's life or health or ability to attain, maintain, or regain maximum function, then the Contractor shall notify that Member of a Service Authorization denial as expeditiously as required by the Member's condition, but not longer than three (3) business days from the Member's request for service.
- 4.1.1.4.5.3. If the Contractor does not notify a Member of a Service Authorization decision within the timeframes in this section, the Contractor shall be deemed to have denied the Service Authorization and that Member shall have any rights relating to the Service Authorization that the Member would have if the Contractor had denied it.
- 4.1.1.4.6. The Contractor shall ensure that all information shown in Exhibit K, Member Information, is made available to every Member.
- 4.1.2. Grievance Process
 - 4.1.2.1. The Contractor shall establish and maintain a grievance process through which Members may any complaint they have that is not the result of an action subject to an appeal.
 - 4.1.2.1.1. The Contractor shall ensure that information about the grievance process, including how to file a grievance, is available to all Members.
 - 4.1.2.1.2. The Contractor shall only create a grievance process that provides a Member sufficient time to disenroll, based on the timeframe specified in 42 CFR 438.56(e)(1), if the Contractor approves a disenrollment in response to a grievance.
 - 4.1.2.1.3. The Contractor shall allow a Member to file a grievance either orally or in writing.
 - 4.1.2.1.4. The Contractor shall make a decision regarding the grievance and provide notice to the Member of this decision within fifteen (15) business days of when the Member files the grievance.
 - 4.1.2.1.4.1. This notice shall be made in a form and format approved by the Department.
 - 4.1.3. Appeal Process
 - 4.1.3.1. The Contractor shall establish and maintain an internal appeal process under which a Member may challenge the denial of coverage of, or payment for, services in accordance with 42 C.F.R. §438.400 *et seq.*, as amended. In addition, the Contractor shall support the Department by attending and responding to State Fair Hearings notices regarding its Members.
 - 4.1.3.2. The Contractor's appeal process shall comply with 10 C.C.R. 2505-10, §8.209, Medicaid Managed Care Grievance and Appeal Processes.

- 4.1.3.3. A Member's request for a review of any action, taken by the Contractor in relation to that Member, shall be considered an appeal.
 - 4.1.3.3.1. A Member or a Provider shall be allowed to appeal any action by filing the appeal within thirty (30) days of when the Contractor has notified the Member or the Provider of the action.
 - 4.1.3.3.2. A Member or a Provider shall be allowed to file an appeal either orally or in writing. If the Member or Provider files the appeal orally, the Contractor shall ensure that the Member or Provider is aware that they must file a signed, written appeal following the filing of oral appeal.
 - 4.1.3.4. Within two (2) business days of Contractor receipt of the Member's or Provider's request for appeal, the Contractor shall send the Member a letter notifying the Member how they may receive a copy of the case file related to the appeal and how they can submit additional information wither in writing or in person to the Contractor.
 - 4.1.3.4.1. The Contractor shall make its decision relating to all appeals within ten (10) business days of receipt of additional information from a Member for that appeal, or within ten (10) business days from when the Member notifies the Contractor that it will not submit any additional information for that appeal.
 - 4.1.3.5. When conducting an appeal, the Contractor shall:
 - 4.1.3.5.1. Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the Member or the Provider requests expedited resolution.
 - 4.1.3.5.2. Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.
 - 4.1.3.5.3. Allow the Member and the Member's representative opportunity, before and during the appeals process, to examine the Member's case file, including medical records, and any other documents and records.
 - 4.1.3.5.4. Consider the Member, the Member's representative or the estate representative of a deceased Member as parties to the appeal.
 - 4.1.3.6. The Contractor shall provide written notice of disposition of each appeal and shall make reasonable efforts to provide the Member oral notice of this disposition. This notice shall include:
 - 4.1.3.6.1. The results and date of the appeal resolution.
 - 4.1.3.6.2. For decisions not wholly in the Member's favor:
 - 4.1.3.6.2.1. The right to request a State Fair Hearing,
 - 4.1.3.6.2.2. How to request a State Fair Hearing,
 - 4.1.3.6.2.3. The right to continue to receive benefits pending a hearing,
 - 4.1.3.6.2.4. How to request the continuation of benefits, and

- 4.1.3.6.2.5. Notice that if the Contractor's action is upheld in a State Fair Hearing, the Member may be liable for the cost of any continued benefits.
- 4.1.3.7. The Contractor shall continue the Member's benefits if all of the following are met:
 - 4.1.3.7.1. The appeal is filed timely in accordance with the requirements of this Contract.
 - 4.1.3.7.2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
 - 4.1.3.7.3. The services were ordered by an authorized provider.
 - 4.1.3.7.4. The authorization period has not expired.
 - 4.1.3.7.5. The Member requests extension of benefits.
- 4.1.3.8. If the Contractor continues or reinstates the Member's benefits while the appeal is pending, the benefits shall be continued until one of the following occurs:
 - 4.1.3.8.1. The Member withdraws the appeal.
 - 4.1.3.8.2. The Member does not request a State Fair Hearing within ten (10) days from when the Contractor mails an adverse decision.
 - 4.1.3.8.3. A State Fair Hearing decision adverse to the Member is made.
 - 4.1.3.8.4. The authorization expires or authorization service limits are met.
- 4.1.3.9. If the final resolution of an appeal upholds the Contractor's action, the Contractor may recover the cost of the continuation of services furnished to the Member while that appeal was pending.
- 4.1.3.10. If the final resolution of an appeal reverses the Contractor's action, and the Contractor did not provide the services while the appeal was pending, then the Contractor shall provide the disputed services promptly after the final resolution and as expeditiously as the Member's health condition requires.
 - 4.1.3.10.1. If the final resolution of an appeal reverses the Contractor's action and the Member received the services from another source because the Contractor did not provide the services, then the Contractor shall pay for those services in accordance with the Department's policy and regulations.
- 4.1.3.11. Notwithstanding the deadlines and due dates in any other section or provision of this Statement of Work, the Contractor shall establish and maintain an expedited appeal process for cases where the Contractor or the Member's Provider determines that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.
 - 4.1.3.11.1. The Contractor shall accept a request for an expedited appeal either orally or in writing. The Member shall not be required to follow up any request for an expedited appeal.
 - 4.1.3.11.2. When the Contractor receives a Member's request for an expedited appeal, the Contractor shall notify that Member of the limited time available for the Member to present evidence and allegations of fact or law, in person or in writing.

- 4.1.3.11.3. The Contractor shall make a decision on all expedited appeals within three (3) business days of the request for that expedited appeal.
- 4.1.3.11.4. The Contractor shall not take any punitive action against a Member, or a Provider supporting a Member's request, in response to the Member requesting an expedited appeal.
- 4.1.3.11.5. If the Contractor denies a Member's request for an expedited appeal, then the Contractor shall treat the appeal as a standard appeal and shall notify the Member of the denial of the expedited appeal within two (2) days in writing and shall make reasonable efforts to notify the Member promptly orally.
- 4.1.3.12. State Fair Hearing
 - 4.1.3.12.1. A Member may request a State Fair Hearing during an appeal or once the Contractor has made a decision regarding an appeal.
 - 4.1.3.12.1.1. A Member shall be allowed to request a State Fair Hearing within thirty (30) days from when the Contractor makes a decision regarding the appeal. If the Member requests the State Fair Hearing before the Contractor has made a decision regarding an appeal, then the Member shall be allowed to make the request within thirty (30) days from the action that lead to the appeal.
 - 4.1.3.12.2. The Contractor shall ensure that each Member is aware of their right to a State Fair Hearing, how to obtain a State Fair Hearing and the representation rules for the hearing.
 - 4.1.3.12.3. The Contractor, the Member and the Member's representative, as applicable, shall be parties to the State Fair Hearing.
- 4.1.4. Member Confidentiality
 - 4.1.4.1. Contractor shall protect the confidentiality of all Member records and other materials, in any form, including electronic that are maintained in accordance with this Contract. Except for purposes directly connected with the administration of the Medicaid program, no information about or obtained from any Member in possession of Contractor shall be disclosed in a form identifiable with the Member without the prior written consent of the Member or the parent or guardian of the Member if the Member is a minor, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical or other form which does not identify particular individuals. Contractor shall have written policies governing access to, duplication and dissemination of, all such information. Contractor shall advise its employees, agents, Participating Providers and Subcontractors, if any, that they are subject to these confidentiality requirements. Contractor shall provide its employees, agents, Participating Providers and Subcontractors, if any, with a copy or written explanation of these confidentiality requirements before access to confidential data is permitted.

- 4.1.4.2. The Contractor shall maintain or make provisions for the maintenance of a Medical Record for each Member according to state and federal laws and regulations. The Medical Record shall accurately represent the full extent of care provided to the Member. The record shall include, at a minimum, medical charts, prescription files, and other documentation sufficient to disclose the quality, quantity, appropriateness and timeliness of services performed under this Contract. It may be reflected and noted in the record that an Advance Directive has been discussed with the Member, if one has been executed. Each Member's record must be legible and maintained in detail consistent with good medical and professional practices that facilitate effective internal and external peer review, medical audit and adequate follow-up treatment.
- 4.1.4.3. The Contractor shall conform to the requirements of 45 C.F.R 205.50, as amended, §10-16-423, C.R.S., as amended, 45 C.F.R. §§160 and 164, as amended, and 42 C.F.R 431.304 - 431.307, as amended, regarding confidentiality of health information about any Member for Covered Services hereunder.
- 4.1.4.4. The Contractor agrees to abide by 42 C.F.R. §431.301, as amended, and § 26-1-114, C.R.S., as amended, regarding the confidentiality of information concerning applicants for and Clients of medical assistance.
- 4.1.5. Marketing
 - 4.1.5.1. The Contractor shall not distribute any marketing materials without the Department's approval.
 - 4.1.5.1.1. The Contractor shall submit all materials relating to Marketing Activities to the Department's designee, and allow the Department's Night State Medical Assistance and Services Advisory Council and the Department to review any materials the Contractor proposes to use in relation to its Marketing Activities before distributing any such materials. Based on this review, the Department may require changes to any materials before the Contractor may distribute those materials, or may disallow the use of any specific materials in its sole discretion.
 - 4.1.5.1.2. The Contractor shall specify methods of assuring the Department that Marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the Members or the Department.
 - 4.1.5.1.3. The Contractor shall distribute all materials to the entire Service Area.
 - 4.1.5.1.4. The Contractor shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.
 - 4.1.5.1.5. The Contractor and any Subcontractors shall not, directly or indirectly, engage in door-to-door, telephone, or other cold call marketing activities, as defined in 422 CFR 438.104(a).
 - 4.1.5.1.6. Marketing materials shall not contain any assertion or statement, whether written or oral, that the potential Member must enroll with the Contractor to obtain benefits or not to lose benefits.

- 4.1.5.1.7. Marketing Materials shall not contain any assertion or statement, whether written or oral, that the Contractor is endorsed by the Centers for Medicare and Medicaid Services, the Federal or State government or similar entity.
- 4.1.5.1.8. The Contractor shall only engage in Marketing Activities in compliance with federal and state laws, regulations, policies and procedures.
- 4.1.6. Member notification of Provider Termination
 - 4.1.6.1. Upon termination of a Provider's agreement or participation with the Contractor, for any reason, the Contractor shall notify any Member, who has selected that provider to be their Primary Care Medical Provider, of that provider's termination, as required in 42 CFR 438.10(f)(5).
 - 4.1.6.1.1. DELIVERABLE: Notice to Members of Provider Termination
 - 4.1.6.1.2. DUE: Fifteen (15) days from the notice of termination
 - 4.1.7. Advance Directives
 - 4.1.7.1. Contractor shall maintain written policies and procedures concerning Advance Directives with respect to all adult Members, as provided in 42 CFR §489. The Contractor shall provide all of the following information to those Members:
 - 4.1.7.1.1. The Member's rights under the law of the State.
 - 4.1.7.1.2. The Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience.
 - 4.1.7.1.3. Contractor shall inform individuals that complaints concerning noncompliance with the Advance Directive requirements may be filed with the Colorado Department of Public Health and Environment.
 - 4.1.8. Incentives to Members
 - 4.1.8.1. The Contractor shall not provide material incentives unrelated to the provision of service as an inducement to the Members to Enroll or Disenroll in the Contractor's Plan or to use the services of a particular Provider. The Contractor shall also ensure that any agreements it has with its Participating Providers prohibit those Providers from providing material incentives unrelated to the provision of service as an inducement to the Members to Enroll or Disenroll in the Contractor's Plan or to use the services of a particular Provider.

4.2. PROVIDER ISSUES

- 4.2.1. Participating Provider Requirements
 - 4.2.1.1. Prior to the Contract's Effective Date, the Contractor shall:
 - 4.2.1.1.1. Verify that all Participating Providers are Medicaid providers.
 - 4.2.1.1.2. Verify that all primary care providers in its network are ACC PCMPs with an executed PCMP contract with their RCCO(s) and the Department.
 - 4.2.1.1.3. Have a written agreement with all Participating Providers indicating that they are willing to take Medicaid FFS clients and ACC clients.

4.2.1.1.3.1. DELIVERABLE: List of All Participating Providers with Medicaid Provider IDs for the Department to Verify.

4.2.1.1.3.2. DUE: Prior to the Contract's Effective Date.

4.2.2. Licensure and Credentialing

4.2.2.1. The Contractor shall have written policies and procedures for the selection and retention of Providers.

4.2.2.2. The Contractor shall verify that all Participating Providers meet licensing and certification requirements.

4.2.2.3. The Contractor's credentialing program shall comply with the standards of the National Committee on Quality Assurance (NCQA) for initial credentialing and re-credentialing of Participating Providers. The Contractor may use information from the accreditation of primary care clinics by the Joint Commission on Accreditation of Health Care Organization (JCAHO) to assist in meeting NCQA credentialing standards.

4.2.2.4. The Contractor's credentialing program shall include policies and procedures for detection and reporting of incidents of questionable practice, in compliance with Colorado statutes and regulations, the Health Care Quality Improvement Act of 1986, and NCQA standards.

4.2.2.5. The Contractor shall assure that all laboratory-testing sites providing services under this Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number. Those laboratories with Certificates of Waiver will provide only the nine (9) types of tests permitted under the terms of the Waiver. Laboratories with Certificates of Registration may perform a full range of laboratory tests.

4.2.2.6. The Contractor's Provider selection policies and procedures shall not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

4.2.3. Provider Insurance

4.2.3.1. The Contractor shall ensure that Participating Providers comply with all applicable local, state and federal insurance requirements necessary in the performance of this Contract. Minimum insurance requirements shall include, but are not limited to all the following:

4.2.3.1.1. Physicians participating in the Contractor's Plan shall be insured for malpractice, in an amount equal to a minimum of five-hundred thousand dollars (\$500,000) per incident and one million five-hundred thousand dollars (\$1,500,000) in aggregate per year.

4.2.3.1.2. Facilities participating in the Contractor's Plan shall be insured for malpractice, in an amount equal to a minimum of five-hundred thousand dollars (\$500,000) per incident and three million dollars (\$3,000,000) in aggregate per year.

- 4.2.3.1.3. Sections 4.2.3.1.1 and 4.2.3.1.2 shall not apply to Physicians and facilities in the Contractor's network which meet any of the following requirements:
 - 4.2.3.1.3.1. The Physician or facility is a public entity or employee pursuant to §24-10-103, C.R.S. of the Colorado Governmental Immunity Act, as amended.
 - 4.2.3.1.3.2. The Physician or facility maintains any other security acceptable to the Colorado Commissioner of Insurance, which may include approved plan of self-insurance, pursuant to §13-64-301, C.R.S., as amended.
 - 4.2.3.1.4. The Contractor shall provide the Department with acceptable evidence that such insurance is in effect upon the Department's request. In the event of cancellation of any such coverage, the Contractor shall notify the Department of such cancellation within two (2) business days of when the coverage is cancelled.
- 4.2.4. Provider Quality of Care Issues
 - 4.2.4.1. For alleged quality of care concerns involving Participating Providers, the Contractor may use the process of its professional review committee, as set forth in §§ 12-36.5-104 and 12-36.5-104.4, C.R.S., when a quality of care concern is brought to its attention. This provision shall not be construed to require the Contractor to disclose any information that is confidential by law.
- 4.2.5. Program Integrity
 - 4.2.5.1. The Contractor shall report all adverse licensure or professional review actions it has taken against any Participating Provider, in accordance with 45 C.F.R. Subtitle A, Part 60, Subpart B, to the National Practitioner Data Bank and to the appropriate State regulatory board.
 - 4.2.5.2. The Contractor shall establish and maintain a compliance program designed to prevent, detect investigate and report fraud, waste and abuse.
 - 4.2.5.2.1. The Contractor shall create a Compliance Program Plan documenting Contractor's written policies and procedures, standards and documentation of practices. The Compliance Program Plan shall be approved by Contractor's Chief Executive Officer and Compliance Officer. The Compliance Program Plan shall be submitted to the Department for review and approval and shall contain, at a minimum:
 - 4.2.5.2.1.1. Provisions for internal monitoring and auditing.
 - 4.2.5.2.1.2. Provisions for prompt response to detected offenses and for development of corrective action initiatives.
 - 4.2.5.2.1.3. Provisions for monitoring Members for improper prescriptions for controlled substances, inappropriate emergency care or card-sharing.
 - 4.2.5.2.1.4. Effective processes to screen all Provider claims, collectively and individually, for potential fraud, waste or abuse.
 - 4.2.5.2.1.5. Effective mechanisms to identify and report suspected instances of Medicaid fraud, waste and abuse.

- 4.2.5.2.1.6. Effective mechanisms to identify and report suspected instances of up-coding and unbundling of services, identifying services never rendered, and identifying inflated bills for services and/or goods provided.
- 4.2.5.2.1.7. Effective processes to ensure that covered services billed by network providers were received by members and that the services received match the billing codes/descriptions.
- 4.2.5.2.2. The Contractor shall review, and update as necessary, the Compliance Program Plan at least annually. Upon completion of its review, the Contractor shall notify the Department of whether it has updated its Compliance Program Plan and, if it has made any updates to changes, deliver the updated plan to the Department for review and approval.
 - 4.2.5.2.2.1. DELIVERABLES: Compliance Program Plan; Updated Compliance Program Plan
 - 4.2.5.2.2.2. DUE: The Compliance Program Plan shall be due no later than thirty (30) days from the Contract's Effective Date; the Updated Compliance Program Plan or notification that the plan was not updated upon review shall be due annually, no later than July 30th
- 4.2.5.3. The Contractor shall suspend payments to any Participating Provider that is actively under investigation for a credible fraud allegation. The Department may suspend managed care capitation payments when an individual network provider is under investigation based upon credible allegations of fraud, depending on the allegations at issue.
- 4.2.5.4. The Department may suspend capitation payments to the Contractor should the Contractor be actively under investigation for credible fraud allegations. If the Department fails to suspend payments to such an entity for which there is a pending investigation of a credible allegation of fraud, without good cause, FFP may be disallowed with regard to such payments to the Contractor.
- 4.2.5.5. The Contractor shall establish written policies for employees requiring all employees to be informed of and detailing compliance with all of the following laws, rules and regulations:
 - 4.2.5.5.1. The False Claims Act, 31 USC §§ 3729, et seq.
 - 4.2.5.5.2. Administrative remedies for false claims and statements.
 - 4.2.5.5.3. State laws relating to civil or criminal penalties for false claims and statements, if any.
 - 4.2.5.5.4. Whistleblower protections under such laws.
 - 4.2.5.5.4.1. DELIVERABLE: Written Policies for Employees Regarding False Claims
 - 4.2.5.5.4.2. DUE: Thirty (30) days from the Contract's Effective Date

- 4.2.5.6. The Contractor shall create and maintain a training program for new and existing employees on the compliance program described in the Compliance Program Plan and the policies regarding false claims described in section 4.2.5.5. This training shall be conducted in a manner that allows the Department to verify that the training has occurred.
- 4.2.5.7. Contractor shall designate a compliance officer and compliance committee that is accountable to the Contractor's senior management.
- 4.2.5.8. Contractor shall have effective lines of communication between the compliance officer and the Contractor's employees for reporting violations.
- 4.2.5.9. Contractor shall enforce its compliance program through well-publicized disciplinary guidelines.
- 4.2.5.10. Contractor shall immediately report known confirmed intentional incidents of fraud and abuse to the Department and to the appropriate law enforcement agency, including, but not limited to, the Colorado Medicaid Fraud Control Unit (MFCU).
- 4.2.5.11. Contractor shall immediately report indications or suspicions of fraud by giving a verbal report to the Department. Contractor shall investigate its suspicions and shall submit its preliminary fraud report containing its findings and concerns to the Department. The Contractor shall continue its investigation and shall provide a final fraud report to the Department detailing the results of the investigation. The Department may approve an extension of time in which to complete the final fraud report upon a showing of good cause.
 - 4.2.5.11.1. DELIVERABLES: Verbal fraud report; preliminary fraud report; final fraud report
 - 4.2.5.11.2. DUE: The verbal fraud report is due within one (1) business day of when the contractor becomes aware of the fraud; the preliminary fraud report shall be due within three (3) business days of the verbal fraud report; the final fraud report shall be due within fifteen (15) business days of the verbal fraud report.
 - 4.2.5.11.3. The Contractor shall provide all of the following information with each fraud report that warrants investigation:
 - 4.2.5.11.3.1. Name and ID number.
 - 4.2.5.11.3.2. Source of complaint.
 - 4.2.5.11.3.3. Type of provider.
 - 4.2.5.11.3.4. Nature of complaint.
 - 4.2.5.11.3.5. Approximate dollars involved.
 - 4.2.5.11.3.6. Legal & administrative disposition of the case.
- 4.2.6. Pharmacy Providers

- 4.2.6.1. The Contractor shall provide or enter into subcontracts with qualified pharmacy Providers for the provision of Covered Drugs as required, and in the manner specified, by Department regulations at 10 C.C.R. 2505-10, §8.205.8. All subcontracts with pharmacy Providers shall be subject to all standards set forth in this Contract.
- 4.2.7. Prompt Payment of Claims
 - 4.2.7.1. The Contractor shall promptly pay claims submitted by Providers, consistent with the claims payment procedures as required by §10-16-106.5, C.R.S., as amended.
- 4.2.8. Termination of Participating Provider Agreements
 - 4.2.8.1. The Contractor shall notify the Department, in writing, of its decision to terminate any existing Participating Provider agreement where such termination will cause the delivery of Covered Services to be inadequate in a given area. The notice to the Department shall include a description of how the Contractor will replace the provision of Covered Services at issue. In the event that the Contractor is unable to adequately replace the affected services to the extent that accessibility will be inadequate in a given area, the Department may impose limitations on Enrollment in the area or eliminate the area from the Contractor's Service Area.
 - 4.2.8.1.1. DELIVERABLE: Notification of Provider Agreement Termination
 - 4.2.8.1.2. DUE: at least sixty (60) days prior to the effective date of the termination unless the termination is based upon quality or performance issues
- 4.2.9. Provider Applications
 - 4.2.9.1. The Contractor shall not discriminate with regards to the participation, reimbursement or indemnification of any provider who is acting within the scope of his/her license or certification under applicable state law, solely on the basis of that license or certification. If the Contractor declines to include an individual Provider or group of Providers in its network, it shall give the affected Providers written notice of the reasons for its decision. In no event shall this provision be construed to:
 - 4.2.9.1.1. Require the Contractor to contract with Providers beyond the number necessary to meet the needs of its Members.
 - 4.2.9.1.2. Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.
 - 4.2.9.1.3. Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Members.
 - 4.2.10. The Contractor shall monitor Covered Services rendered by Participating Providers for quality, appropriateness and Member outcomes. In addition, the Contractor shall monitor for compliance with requirements for Medical Records, data reporting, and other applicable provisions of this Contract.

SECTION 5.0 REPORTING

5.1. GENERAL REPORTING REQUIREMENTS

- 5.1.1. For all reports described in this Contract, the Contractor shall meet the following requirements:
 - 5.1.1.1. The Contractor shall deliver all reports to the Department and ensure that those reports are delivered in a timely manner.
 - 5.1.1.2. The Contractor shall ensure that all reports are complete, contain all required elements and are presented in a Department-approved format.
 - 5.1.1.3. The reports shall not contain any inaccuracies or present insufficient data.
- 5.1.2. Any report that does not meet the requirements of this section shall be considered improperly submitted.
- 5.1.3. For any improperly submitted report, the Contractor shall provide a corrective action plan to remedy any identified deficiencies in a report, as directed by the Department, within five (5) business days of notification by the Department of the improper submission of that report.
 - 5.1.3.1. The Contractor shall remedy all identified deficiencies within five (5) business days of its submission of its corrective action plan to the Department unless the Department agrees to a longer period in writing.
- 5.1.4. Report Verification
 - 5.1.4.1. The Department may, in its sole discretion, verify any information the Contractor reports to the Department for any reason. The Department may use any appropriate, efficient or necessary method for verifying this information including, but not limited to:
 - 5.1.4.1.1. Fact-checking
 - 5.1.4.1.2. Auditing reported data
 - 5.1.4.1.3. Requesting additional information
 - 5.1.4.1.4. Performing site visits
 - 5.1.4.2. In the event that the Department determines that there are errors or omissions in any reported information, the Contractor shall produce an updated report, which corrects all errors and includes all omitted data or information, and submit the updated report to the Department within ten (10) days from the Department's request for the updated report.
 - 5.1.4.2.1. DELIVERABLE: Updated reports.
 - 5.1.4.2.2. DUE: Ten (10) days from the Department's request for an updated or corrected report.
- 5.1.5. Data Analysis and Reports

- 5.1.5.1. The Contractor shall share with the PCMPs, the SDAC and the Department any specific findings or important trends discovered through the Contractor's analysis of the available data and information.
- 5.1.5.2. The Contractor shall educate and inform the PCMPs and providers about the data reports and systems available to the providers and the practical uses of the available reports.
- 5.1.5.3. The Contractor shall take appropriate action, based on the results of its searches, queries and analyses, to improve performance, target efforts on areas of concern and apply the information to make changes and improve the health outcomes of its members.
- 5.1.5.3.1. The Department may request that the Contractor report the results of any analysis it performs. At the Department's request, the Contractor shall report the results of the analyses it performed to the Department and what steps it intends to take based on those analyses, within ten (10) days of the Department's request. The Department may request additional information, that the Contractor perform further analyses or that the contractor modify any steps it intends to take at the Department's sole discretion.

5.2. ENROLLMENT/DISENROLLMENT REPORTING

- 5.2.1. The Contractor shall submit a quarterly Enrollment/Disenrollment report to the Department. The report shall provide, at a minimum, all of the following:
 - 5.2.1.1. A detailed summary and analysis of all Enrollment and Disenrollment activities.
 - 5.2.1.2. Overall trends relating to Disenrollment and specific reasons for Disenrollment including, but not limited to:
 - 5.2.1.2.1. Voluntary Disenrollment.
 - 5.2.1.2.2. Members utilizing the Contractor's grievance process regarding requests for Disenrollment.
 - 5.2.1.2.3. Involuntary Disenrollment information and trends.
 - 5.2.1.3. The Enrollment/Disenrollment Report shall be submitted in a format approved by the Department.
 - 5.2.1.3.1. DELIVERABLE: Enrollment/Disenrollment Report
 - 5.2.1.3.2. DUE: Quarterly, within thirty (30) days of the end of the calendar quarter for which the report covers.
- 5.2.2. The Contractor shall submit each quarter an enrollment attribution file of all client and provider relationships, including, at a minimum:
 - 5.2.2.1. Month of Attribution;
 - 5.2.2.2. Client Name;
 - 5.2.2.3. Client Date of Birth;
 - 5.2.2.4. Member ID;

- 5.2.2.5. Provider Identifier (NPI) of assigned primary care practice or physician;
- 5.2.2.6. Associated Medicaid Provider Identifier (or blank if not applicable);
- 5.2.2.7. Provider address; and
- 5.2.2.8. Provider specialty.
- 5.2.2.9. DELIVERABLE: Enrollment Attribution Flat File
- 5.2.2.10. DUE: Quarterly, within thirty (30) days of the end of the calendar quarter for which the report covers

5.3. MEMBER OUTREACH AND STAKEHOLDER FEEDBACK REPORTING

- 5.3.1. The Member Outreach and Stakeholder Feedback Report shall contain:
 - 5.3.1.1. A summary of the feedback received from Members and other stakeholders, through any advisory committee or through any other means.
 - 5.3.1.2. A description of trends and themes in the feedback received.
 - 5.3.1.3. A description of overarching issues to address or system-wide problems that must be solved and a proposal to address these issues or solve the problems.
 - 5.3.1.4. A summary of the feedback and complaints from Members, providers and the community at large and any advice or views expressed by the Contractor's Performance Improvement Advisory Committee.
 - 5.3.1.5. Challenges identified in serving the Expansion Population.
 - 5.3.1.6. Lessons learned from the Expansion Population related to their health needs and behaviors.
- 5.3.2. The Contractor shall provide the Member Outreach and Stakeholder Feedback Report to the Department on a quarterly basis, within thirty (30) days from the end of the quarter that the report covers.
- 5.3.3. The Stakeholder feedback report may contain information that is not reflected in the Contractor's regular grievance process and the information contained in such a report is not indicative of a weakness or limitation of the Contractor of the Contractor's system.
 - 5.3.3.1. DELIVERABLE: Member Outreach and Stakeholder Feedback Report.
 - 5.3.3.2. DUE: Thirty (30) days from the end of the quarter that the report covers.

5.4. PROVIDER NETWORK REPORTING

- 5.4.1. The Contractor shall provide an annual Provider Network Strategic Plan to the Department. This Provider Network Strategic Plan shall contain, at a minimum, all of the following:
 - 5.4.1.1. The Contractor's current and future strategic planning relating to its Provider network.
 - 5.4.1.2. The Contractor's approach to meeting all access standards described in section 2.5.1.

- 5.4.1.3. All applicable metrics relating to the Provider network including, but not limited to:
 - 5.4.1.3.1. PCMP to Member Ratio.
 - 5.4.1.3.2. Physician Specialist to Member Ratio.
 - 5.4.1.3.3. Number of Members who are more than thirty (30) miles or thirty (30) minutes travel time, whichever area is larger, from a Provider in the Contractor's Network.
 - 5.4.1.3.4. Population demographics, as determined by the Department, of the Contractor's Providers and Members.
 - 5.4.1.3.5. Number of PCMPs offering extended hours to Members.
- 5.4.1.4. The Provider Network Strategic Plan shall be submitted in a format approved by the Department.
 - 5.4.1.4.1. DELIVERABLE: Provider Network Strategic Plan.
 - 5.4.1.4.2. DUE: Annually, within the first three (3) months of the state fiscal year.
- 5.4.2. The Contractor shall provide a quarterly Provider Network Capacity and Services Report to the Department regarding the Contractor's capacity and services.
 - 5.4.2.1. This Provider Network Capacity and Services report shall contain support showing that the Contractor meets, at a minimum, all of the following requirements:
 - 5.4.2.1.1. The Contractor provides an appropriate range of preventive care, primary care and specialty services that is adequate for the anticipated number of Members.
 - 5.4.2.1.2. The Contractor maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of Members in the Service Area.
 - 5.4.2.1.3. The Contractor meets any other requirements described in 42 C.F.R. §438.207(c).
 - 5.4.2.2. The Contractor shall include the use of Electronic Health Records (EHR) by provider and provider specialty and stage of meaningful use (<http://www.healthit.gov/providers-professionals/how-attain-meaningful-use>), if applicable. For all providers, the Contractor shall indicate whether they are connected to the statewide Health Information Exchange (HIE) network (such as Quality Health Network or the Colorado Regional Health Information Organization).
 - 5.4.2.3. In the event that the Provider Network Capacity and Services Report shows that the Contractor's Provider Network is insufficient to meet the access standards described in section 2.5.1, then the Contractor shall create and submit to the Department a corrective action plan on a schedule determined by the Department. The Department will review the corrective actions plan and may require changes to the plan before approving the plan. The Contractor shall not implement any corrective action plan until it has been approved by the Department.
 - 5.4.2.3.1. DELIVERABLE: Network Capacity and Services Corrective Action Plan

- 5.4.2.3.2. DUE: As requested by the Department
- 5.4.3. The Contractor shall create and document a communication plan to communicate with all providers, behavioral health managed care organization and PCMPs in its network and other community resources with which it has relationships, and to promote communication amongst the providers.
 - 5.4.3.1. The communication plan may include the following methods:
 - 5.4.3.1.1. Assignment of providers to a specific provider relations consultant or point-of-contact with the Contractor's organization.
 - 5.4.3.1.2. Holding information sessions for interested providers at practice association meetings or conferences.
 - 5.4.3.1.3. Providing orientation sessions for providers that are new to the Contractor's network.
 - 5.4.3.1.4. Hosting forums for ongoing training regarding the ACC program and services the contractor offers.
 - 5.4.3.1.5. Posting provider tools, trainings, informational material and the Contractor's contact details on the internet in easily accessible formats.
 - 5.4.3.1.6. Developing standard communication intervals at which the Contractor will contact providers to maintain connection and lines of communication.
 - 5.4.3.1.7. Distributing written provider communications at least twice a year to promote continuous provider interest and involvement.
 - 5.4.3.2. The Contractor shall submit its initial communication plan for the Department's review. The Contractor shall submit any significant changes to the Communication plan for the Department's review and approval.
 - 5.4.3.2.1. DELIVERABLE: PCMP Communication Plan.
 - 5.4.3.2.2. DUE: Ten (10) days from the Contract's Effective Date for the initial communication plan and thirty (30) days from the date of any change for an updated communication plan.

5.5. APPEAL REPORTING

- 5.5.1. The Contractor shall provide a quarterly Appeal Report to the Department. This report shall meet the following requirements:
 - 5.5.1.1. The Appeal Report shall follow the format provided by the Department and contain any appeal information requested by the Department.
 - 5.5.1.2. The report shall document Members' appeals and show how those appeals were tracked, resolved and assessed.
 - 5.5.1.3. The report shall contain a written summary analysis and a categorical analysis of the appeal data documented in the report. Based on this report, the Department may request a detailed report on any or all of the appeals shown on that report.
 - 5.5.1.3.1. DELIVERABLE: Appeal Report

5.5.1.3.2. DUE: Quarterly, within thirty (30) days of the end of the calendar quarter for which the report covers.

5.6. CLINICAL REPORTING

5.6.1. HEDIS Report

5.6.1.1. The Contractor shall provide an annual HEDIS Report to the Department. This report shall meet the following requirements:

5.6.1.1.1. The HEDIS Report shall contain all HEDIS measures determined by the Department for that year.

5.6.1.1.2. The HEDIS Report shall follow the format approved by the Department

5.6.1.1.2.1. DELIVERABLE: HEDIS Report

5.6.1.1.2.2. DUE: Annually, by June 30th for the report covering the state fiscal year that ends on that day.

5.6.2. EPSDT Report

5.6.2.1. The Contractor shall complete and submit an annual EPSDT Report to the Department.

5.6.2.2. The EPSDT Report shall be provided to the Department on the Form CMS-416 and contain all information required for that form for the most recent period from October 1st through September 30th.

5.6.2.2.1. DELIVERABLE: EPSDT Report

5.6.2.2.2. DUE: Annually by February 1st for the prior period from October 1st through September 30th

5.6.3. Serious Reportable and Never Events Reporting

5.6.3.1. The Contractor shall provide a quarterly Serious Reportable and Never Events Report in a format as directed by the Department. This report shall contain all events described in Exhibit J, Serious Reportable Events or Never Events, attached and incorporated herein by reference for the Contractor and all Subcontracted facilities that provide inpatient services to Clients. The report shall also contain any service with the POA indicator at the time of a hospital admission.

5.6.3.1.1. DELIVERABLE: Serious Reportable and Never Events Report

5.6.3.1.2. DUE: Quarterly, within thirty (30) days of the end of the calendar quarter for which the report covers.

5.7. FINANCIAL REPORTING

5.7.1. The Contractor shall submit its audited annual financial statements prepared in accordance with Statutory Accounting Principles (SAP) certified by an independent public accountant to the Department or the Department's designee.

5.7.1.1. The report will be in a format determined by the Department and modified as needed.

5.7.1.1.1. DELIVERABLE: Audited Annual Financial Report.

- 5.7.1.1.2. DUE: Annually, on or before December 1st.
- 5.7.2. Health Insurance Providers Fee Reporting
 - 5.7.2.1. In the event that the Contractor is subject to any Health Insurance Providers Fee under 26 CFR Part 57 and required to file a form 8963, then the Contractor shall create a Health Insurance Providers Fee Report to the Department that contains all of the following information:
 - 5.7.2.1.1. A copy of the Form 8963 as well as copies of any corrected Form 8963s filed with the Internal Revenue Service (IRS).
 - 5.7.2.1.2. The preliminary and final calculations of the fee from the IRS, even if the calculated fee was \$0.00.
 - 5.7.2.1.3. An allocation of the fee attributable to the Work under this Contract.
 - 5.7.2.2. Any additional information related to the Health Insurance Providers Fee, as determined by the Department.
 - 5.7.2.2.1. The Contractor shall deliver the Health Insurance Providers Fee Report for each year that it is required to file a form 8963 with the IRS.
 - 5.7.2.2.1.1. DELIVERABLE: Health Insurance Providers Fee Report.
 - 5.7.2.2.1.2. DUE: Annually, no later than October 1st of each year in which the Contractor filed a form 8963.
- 5.7.3. The Contractor shall provide other financial reports as requested by the Department within 30 days following the request.

SECTION 6.0 REIMBURSEMENT

6.1. PAYMENT OF MONTHLY CAPITATION

- 6.1.1. For each Member Enrolled with the contractor, the Department shall pay the Contractor the Monthly Payment Rate specified in Exhibit C.
- 6.1.2. The Department shall remit payment of the Monthly Payment Rate to the Contractor, on or before the twentieth (20th) business day of each month.
- 6.1.3. The Department shall remit payment through an electronic transfer of funds to the bank account designated by the Contractor. The Department shall provide the Contractor with a monthly payment report through the MMIS.
- 6.1.4. The Contractor shall be responsible for the accuracy of direct deposit information provided to the Department and for updating such information as needed.
- 6.1.5. The Monthly Payment Rate shall be considered payment in full for all Covered Services set forth in Exhibit B.
- 6.1.6. In the event of conflict or inconsistency, or alleged conflict or inconsistency, between Exhibit B and any other provision of the Contract, Exhibit B shall prevail over other provisions of this Contract, pages 1 to 22 and Exhibits A and C through P (see Section 19. I., Order of Precedence).

6.2. CALCULATION OF MONTHLY CAPITATION RATE

- 6.2.1. The Monthly Payment Rates set forth in Exhibit C are based on the costs of providing the Covered Services set forth in Exhibit B which shall not exceed one hundred percent (100%) of the direct health care cost of providing these same services to an actuarially equivalent Colorado Medicaid population group consisting of unassigned recipients and recipients in the Primary Care Physician Program. Calculation of the Monthly Payment Rate includes, for selected categories of aid, a risk adjustment for health status. Rates will be set in accordance with all applicable state statutes, federal regulations and actuarial standards of practice. The actuarial basis for calculation of the Monthly Payment Rate is set forth in the actuarial certification which is part of and incorporated herein as Exhibit C.
- 6.2.2. The Monthly Payment Rate may be adjusted during the performance period of this Contract pursuant to an executed amendment, upon approval of the State Controller or his/her designee.

6.3. RECOUPMENTS

- 6.3.1. The Department shall recoup Monthly Payment Rate amounts paid to the Contractor in error. Error may be either human or machine error on the part of the Department, the Contractor or otherwise. Error includes, but is not limited to, lack of eligibility, computer error, move by the Member outside the Contractor's Service Area, or situations where the Member cannot use the Contractor's facilities.
- 6.3.2. The Department shall recoup, from the Contractor, all claims for Covered Services paid by the Department, on behalf of Members who are retroactively Enrolled in the Contractor's Plan.
- 6.3.3. The Contractor shall refund to the Department any overpayments due the Department within thirty (30) days after discovering the overpayments or being notified by the Department that overpayments are due. If the Contractor fails to refund the overpayments within thirty (30) days, the Department shall deduct the overpayments from the next payment to the Contractor.
- 6.3.4. The Contractor's obligation to refund all overpayments continues subsequent to the termination of the Contract. If the Contract has terminated, the Contractor shall refund any overpayments due to the Department, by check or warrant, with a letter explaining the nature of the payment, within ninety (90) days of termination.
- 6.3.5. Payments made by the Department to the Contractor due to the Contractor's omission, fraud, and/or defalcation, as determined by the Department, shall be deducted from subsequent payments.
- 6.3.6. Where membership is disputed between two Contractors, the Department shall be final arbitrator of membership and shall recoup any Monthly Payment Rate amounts paid in error.
- 6.3.7. The Contractor's obligation to refund all calculated MLR rebates continues subsequent to the termination of the Contract.

6.4. THIRD PARTY PAYER LIABILITY

- 6.4.1. All Members are required to assign their rights to any benefits to the Department and agree to cooperate with the Department in identifying third parties who may be liable for all or part of the costs of providing services to the Member, as a condition of participation in the Medicaid program.
- 6.4.2. The Contractor shall develop and implement systems and procedures to identify potential third parties that may be liable for payment of all or part of the costs for providing Covered Services under this Contract.
 - 6.4.2.1. Potential liable third parties shall include any of the sources identified in 42 C.F.R. Section 433.138 relating to identifying liable third parties. The Contractor shall coordinate with the Department to obtain information from other state and federal agencies and the Contractor shall cooperate with the Department in obtaining information from commercial third party resources.
 - 6.4.2.2. The Contractor shall, on a monthly basis, notify the Department's fiscal agent, by telephone or in writing, of any third party payers, excluding Medicare, identified by the Contractor. If the third party payer is Medicare, the Contractor shall notify the Department and provide the Member's name and Medicaid identification along with the Medicare identification number. If the Member has health insurance coverage other than Medicare, the Contractor shall submit the following information:
 - 6.4.2.2.1. Medicaid identification number;
 - 6.4.2.2.2. Member's social security number;
 - 6.4.2.2.3. Member's relationship to policyholder;
 - 6.4.2.2.4. Name, complete address, and telephone number of health insurer;
 - 6.4.2.2.5. Policy Member identification and group numbers;
 - 6.4.2.2.6. Policy Member's social security number;
 - 6.4.2.2.7. Policy Member's full name, complete address and telephone number; and
 - 6.4.2.2.8. Daytime telephone number where Member can be reached.
 - 6.4.2.3. The Contractor shall actively pursue and collect from third party resources that have been identified except when it is reasonably anticipated by the Contractor that the cost of pursuing recovery will exceed the amount that may be recovered by the Contractor.
 - 6.4.2.4. The Contractor shall provide a quarterly report of all third party recovery efforts and amounts recovered by Medicaid client ID, category of assistance and date of service to the Department. The report shall be provided on compact disc (CD) or by encrypted email, no later than thirty (30) days following the end of each quarter.

- 6.4.2.5. In addition to compensation paid to the Contractor under the terms of this Contract, the Contractor may retain as income all amounts recovered from third party resources, up to the Contractor's reasonable and necessary charges for services provided in-house and the full amounts paid by the Contractor to Participating Providers, as long as recoveries are obtained in compliance with the Contract and state and federal laws.
- 6.4.2.6. The Contractor shall not restrict access to Covered Services due to the existence of possible or actual third party liability.
- 6.4.2.7. The Contractor shall inform Members, in its written communications and publications that Members shall comply with the Contractor's protocols, including using Providers within the Contractor's network, prior to receiving Non-emergency medical care. The Contractor shall also inform its Members that failure to follow the Contractor's protocols will result in a Member being liable for the payment or cost of any care or services that the Contractor would have been liable to pay. If the Contractor substantively fails to communicate the protocols to its Members, the Member is not liable to the Contractor or the Provider for payment or cost of the care or services.
- 6.4.2.8. The Contractor shall inform Members, in its written communications and publications, that when a third party is primarily liable for the payment of the costs of a Member's medical benefits, the Member shall comply with the protocols of the third party, including using Providers within the third party's network, prior to receiving Non-emergency medical care.
- 6.4.2.9. With the exception of Section 6.4.2.10 and except as otherwise specified in contracts between the Contractor and Participating Providers, the Contractor shall pay all applicable co-payments, coinsurance and deductibles for approved Covered Services for the Member from the third party resource using Medicaid lower-of pricing methodology except that, in any event, the payments shall be limited to the amount that Medicaid would have paid under Medicaid fee-for-service:
- 6.4.2.9.1. The sum of reported third party coinsurance and/or deductible or
- 6.4.2.9.2. The Colorado Medicaid allowed rate minus the amount paid by the third party, whichever is lower.
- 6.4.2.10. The Contractor shall pay, except as otherwise specified in contracts between the Contractor and Participating Providers, all applicable copayment, coinsurance and deductibles for approved Medicare Part B Services processed by Medicare Part A. These services include therapies and other ancillary services provided in a skilled nursing facility, outpatient dialysis center, independent rehabilitation facility or rural health clinic. In any event, payments shall be limited to the amount that Medicaid would have paid under Medicaid fee-for-service.

- 6.4.2.11. The Contractor shall also inform its Members, in its written communications and publications, that failure to follow the third party's protocols will result in a Member being liable for the payment or the cost of any care or any service that the third party would have been liable to pay except that, if the third party or the service Provider substantively fails to communicate the protocols to the Member, the items or services the third party is liable for are non-reimbursable under the terms of this Contract and the Member is not liable to the Provider.
- 6.4.2.12. The Contractor shall include information in the Contractor's Member handbook regarding its rights and the Member's obligations under this section of the Contract and Section 25.5-4-301, C.R.S.
- 6.4.2.13. Benefits for Members shall be coordinated with third party auto insurance.

6.5. MEDICAL LOSS RATIO (MLR)

6.5.1. MLR Calculation

- 6.5.1.1. The Department or its agent will calculate a plan-wide Medical Loss Ratio (MLR) each SFY using medical and administrative cost data from encounter data, audited financial statements and reporting, and flat file submissions.
- 6.5.1.2. The MLR will be calculated by dividing the sum of the direct, indirect, and sub-contracted costs for providing all Covered Services provided under this Contract (Medical Spend) by total capitation payments made to the Contractor (i.e. Medical Spend / total capitation payments) for every annual measurement period, with supplemental information, subject to Department approval.
 - 6.5.1.2.1. The first annual measurement period will begin upon execution of this Contract and end on June 30, 2015.
 - 6.5.1.2.2. Subsequent annual measurement periods will align with the state fiscal year.
 - 6.5.1.2.3. The Department will allow for four (4) months claims runout before calculating the Contractor's MLR. The calculation of the MLR may take an additional three (3) months.
 - 6.5.1.2.4. The Department will calculate the MLR after any annual adjustments are made, including, at a minimum, any risk corridor rate calculations for the Medicaid expansion populations. The Department will provide documentation of the methodology it will use for the MLR and any adjustments, along with supporting data and documentation.
 - 6.5.1.2.5. The Contractor must submit all encounters, audited financial statements and reporting, and flat files for the measurement period, before the Department can calculate the MLR. See section 3.9.6 Encounter Claims Data Provisions and Exhibit O Medical Loss Ratio (MLR) Calculation Template.
 - 6.5.1.2.6. The Contractor's Medical Spend will be calculated and verified using both encounter data submitted through the State's Medicaid Management Information System (MMIS), as well as audited supplemental data provided in the Contractor's annual financial reporting.

- 6.5.1.2.7. The MLR shall be rounded to three decimal places. For example, if the MLR is 0.8255 or 82.55%, it shall be rounded to 0.826 or 82.6%.
- 6.5.1.3. MLR Target: The MLR Target is ninety-three point five percent (93.5%).
- 6.5.1.4. Adjusted MLR Target: The MLR Target will be decreased by two percent (2%) for each quality measure target (MLR Quality Target) that the Contractor meets or exceeds (see 6.5.2.3. Quality Target Table). The lowest possible Adjusted MLR Target is eight percent (8%) lower than the MLR Target, or eighty-five point five percent (85.5%). If the Contractor does not meet any MLR Quality Targets, then the Adjusted MLR Target is equal to the MLR Target, ninety-three point five percent (93.5%).
- 6.5.1.5. If the Contractor's MLR does not meet or exceed the Adjusted MLR Target, then the Contractor shall reimburse the Department the difference using the following formula:
 - 6.5.1.5.1. Total amount of capitations payments received by the Contractor multiplied by the difference between the Contractor's MLR and the Adjusted MLR Target.
- 6.5.1.6. The Department will provide documentation of the methodology it will use for this calculation, along with supporting data and documentation.
- 6.5.1.7. The Contractor shall reimburse the Department within thirty (30) days of the Department finalizing the MLR calculation. The Department shall designate the MLR rebate and initiate the recovery of funds process by providing notice to the Contractor of the amount due, pursuant to 10 C.C.R. 2505-10, Section 8.050.3 A-C Provider Appeals, as well as Section 8.050.6 Informal Reconsiderations in Appeals of Overpayments Resulting from Review or Audit Findings.
- 6.5.2. MLR Quality Targets
 - 6.5.2.1. The Department will use the following four (4) quality metrics to measure the performance of the Contractor in relation to the Adjusted MLR Target through the end of SFY14-15. HEDIS measures utilized for the calculation will be based upon audited results produced by the Contractor for the 2015 NCQA and EQRO reporting cycle.
 - 6.5.2.1.1. Adult Body Mass Index (BMI) Assessment (HEDIS - ABA)
 - 6.5.2.1.1.1. Target: eighty-two point thirty three percent (82.33%).
 - 6.5.2.1.2. Comprehensive Diabetes Care: LDL Management and Control - LDL-C Level <100 mg/dL (HEDIS - AMA)
 - 6.5.2.1.2.1. Target: forty point zero one percent (40.01%).
 - 6.5.2.1.3. Anti-depressant Medication Management (HEDIS - CDC)
 - 6.5.2.1.3.1. Targets:
 - 6.5.2.1.3.1.1.1. Effective Acute Phase Treatment: fifty six point zero five percent (56.05%).
 - 6.5.2.1.3.1.1.2. Effective Continuation Phase Treatment: forty point zero six (40.06%).

- 6.5.2.1.3.2. The Contractor must meet both targets in order to receive any credit for this quality metric.
- 6.5.2.1.3.3. The Contractor must only include Members enrolled in this Contract when calculating the three (3) HEDIS quality metrics.
- 6.5.2.1.3.4. The three (3) HEDIS quality metrics must be third party verified by the Contractor's National Committee for Quality Assurance (NCQA) auditor and submitted to the Department's EQRO vendor by June 30, 2015.
- 6.5.2.1.4. Patient Activation Measure (PAM): Process Development and Screening Data Collection.
 - 6.5.2.1.4.1. Target:
 - 6.5.2.1.4.1.1. Implementation of PAM in ten (10) PCMPs, serving in aggregate at least fifty percent (50%) of the enrolled population by July 1, 2015.
 - 6.5.2.1.4.1.2. The Department will verify this target using the PAM Assessment Report.
 - 6.5.2.1.4.2. The Contractor shall provide two (2) PAM reports to the Department annually, which include:
 - 6.5.2.1.4.2.1. The PAM Assessment Report
 - 6.5.2.1.4.2.1.1. The report shall be derived from Insignia Health's PAM software and shall be sent directly to the Department.
 - 6.5.2.1.4.2.1.2. The report shall only include Members enrolled in this Contract.
 - 6.5.2.1.4.2.1.3. The report shall contain, at a minimum, all of the following:
 - 6.5.2.1.4.2.1.3.1. Client name;
 - 6.5.2.1.4.2.1.3.2. Client Medicaid ID;
 - 6.5.2.1.4.2.1.3.3. Survey type;
 - 6.5.2.1.4.2.1.3.4. Survey date;
 - 6.5.2.1.4.2.1.3.5. Activation Score;
 - 6.5.2.1.4.2.1.3.6. PAM Level; and
 - 6.5.2.1.4.2.1.3.7. Responses to all PAM assessment questions.
 - 6.5.2.1.4.2.1.4. DELIVERABLE: PAM Assessment Report.
 - 6.5.2.1.4.2.1.5. DUE: Annually, within thirty (30) days of the end of the SFY for which the report covers.
 - 6.5.2.1.4.2.2. PAM Roadmap Report
 - 6.5.2.1.4.2.2.1. The report shall include, at a minimum:
 - 6.5.2.1.4.2.2.1.1. Year-end assessment of deployment and baseline data development plan;
 - 6.5.2.1.4.2.2.1.2. Identification of successes, lessons learned and gaps; and

- 6.5.2.1.4.2.2.1.3. Year two (2) roadmap for ongoing use of PAM data in further population analysis, stratification, and planning.
- 6.5.2.1.4.2.2.2. DELIVERABLE: PAM Roadmap Report
- 6.5.2.1.4.2.2.3. DUE: Within thirty (30) days of the end of the SFY for which the report covers.
- 6.5.2.1.4.3. The Contractor must meet the PAM MLR Target, and submit both deliverables to the Department in order to receive any credit for this MLR Quality Measure.

6.5.2.2. Quality Targets Table:

Quality Measure	Target(s)/ Deliverable(s)	Adjustment Made to the MLR if the Contractor meets the Target
HEDIS: Adult Body Mass Index (BMI) Assessment	82.33%	Subtract two percent (-2%)
HEDIS: Comprehensive Diabetes Care: LDL Management and Control - LDL-C Level <100 mg/dL.	40.01%	Subtract two percent (-2%)
HEDIS: Anti-depressant Medication Management.	1. Effective Acute Phase Treatment: 56.05%. 2. Effective Continuation Phase Treatment: 40.06%	Subtract two percent (-2%)
Patient Activation Measure (PAM): Process Development and Screening Data Collection	1. Implementation of PAM in 10 PCMPs, serving at least 50% of the Contractor's enrollees. 2. PAM Assessment Report 3. PAM Roadmap Report	Subtract two percent (-2%)
Total		Subtract eight percent (-8%)

- 6.5.2.3. In collaboration with the Contractor, the Department will set the MLR Quality Measure Targets for SFY15-16.
- 6.5.2.4. The Department intends to use the following four (4) quality metrics to measure the performance of the Contractor in relation to the Adjusted MLR Target for SFY15-16:
 - 6.5.2.4.1. NQF #0421 (CQM29v2): Body Mass Index (BMI) Screening and Follow-Up
 - 6.5.2.4.2. NQF #0418 (CQM2v3): Screening for Clinical Depression and Follow-Up Plan
 - 6.5.2.4.3. NQF #0064 (CQM163v2): Low Density Lipoprotein (LDL) Management

- 6.5.2.4.4. PAM: Process Development and Screening Data Collection with Follow Up.
- 6.5.2.5. To the extent that the Contractor has access to identifiable, client-level clinical quality measure (CQM) data relevant to the MLR Quality Targets in an electronic format, the Contractor shall share this data with the Department. The Contractor will work with the Department to establish an appropriate format and method of data transfer.

6.6. PAYMENTS TO PRIMARY CARE PHYSICIANS

- 6.6.1. The Contractor shall demonstrate compliance with the provisions set forth in Section 1202 of the Patient Protection and Affordable Care Act, “Payments to Primary Care Physicians,” (hereinafter “Section 1202”) by the Effective Date. To demonstrate its compliance, the Contractor shall provide, at a minimum, documentation of its compliance as a Managed Care Organization, including all requirements set forth by CMS. The Department will then submit the information provided by the Contractor to CMS as part of the Department’s compliance.
- 6.6.2. In accordance with 42 C.F.R. 438.6(c)(3)(v) and (c)(5)(vi) the Contractor shall adhere to all Contract requirements for this provision specifically:
- 6.6.2.1. The Contractor is required to pass on the full benefit of the payment increase to the eligible providers;
- 6.6.2.2. The Contractor is required to adhere to the definitions and requirements for eligible providers and services as specified in the statute and regulation; and
- 6.6.2.3. The Contractor is required to submit sufficient documentation, as specified by the state, to validate that the enhanced payments were made to eligible providers.
- 6.6.3. The Contractor shall collect self-attestation forms from providers in the Contractor’s network and audit those self-attesting providers. In the event that the Department requests this from the Contractor, the Contractor shall ensure that all forms are completed and collected, and all audits are performed, in accordance with Section 1202, guidance and direction provided by CMS, and guidance and direction provided by the Department.
- 6.6.4. The Department will calculate the appropriate supplemental payment for eligible physician services using risk model 3, Non-Risk Reconciled Payments for Enhanced Rates, as outlined in the Technical Guidance and Rate Setting Practices’ template Section 2, Subsection 2.3 (document provided by CMS). As defined in the guidance for risk model 3, all 1202 payments are separate from the normal monthly capitation payment process. The detail of the supplemental payment calculation plan is subject to CMS’ approval.
- 6.6.5. Eligible physician services described in Section 1202 will be eligible for the appropriate supplemental payment retroactively to January 1, 2013 for eligible physicians that have submitted self-attestation forms to the Contractor on or before March 31, 2013. For eligible physicians that submitted self-attestation forms to the Contractor after March 31, 2013, the appropriate supplemental payment for eligible physician services as described in Section 1202 will apply only to services incurred on or after the date of self-attestation.

6.7. DISPROPORTIONATE SHARE HOSPITAL

6.7.1. The Contractor shall submit data according to the specifications in Exhibit N, Disproportionate Share and Graduate Medical Education Hospital Reporting, attached and incorporated herein by reference. The Contractor shall certify all data submitted is accurate, complete and truthful based on the Contractor's best knowledge, information and belief. This certification shall be signed by either the Chief Executive Officer or the Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to, the Chief Executive Officer or Chief Financial Officer.

6.8. FQHC WRAP-AROUND ENCOUNTER REIMBURSEMENT

6.8.1. Payments to Contractor for FQHC Services:

6.8.1.1. Each FQHC has an encounter rate calculated in accordance with 10 CCR 2505-10 8.700.6C

6.8.1.1.1. The Department shall notify the Contractor of the FQHC rates.

6.8.1.2. The Contractor shall reimburse the FQHC the encounter rate in accordance with 10 CCR 2505-10 8.700.6 for each FQHC visit, for services identified in 10 CCR 2505-10 8.700.3 for allowable cost identified in 10 2505-10 8.700.5.

6.8.1.3. FQHC visit as defined in 10 CCR 2505-10 8.700.1.

6.8.1.4. If multiple services are provided by an FQHC within one visit, the Contractor will require a claims submission from the FQHC with multiple lines of service and the same claim number. The Contractor is required to pay the FQHC no less than the encounter rate for each visit minus any third party payments, including Member co-payments as identified in the Covered Services Exhibit B of this Contract.

6.8.2. Encounter submission minimum requirements

6.8.2.1. In order for the Contractor to receive the FQHC wrap around payment for payments the Contractor has made to the FQHCs, the Contractor shall submit to the Department, a compact disc (CD), or equivalent data media, containing encounter activities for all FQHCs that billed the Contractor in the prior month. Each encounter claim identified on the compact disc shall contain the following information:

6.8.2.1.1. Date report sent to Department;

6.8.2.1.2. Provider number (Contractor ID number);

6.8.2.1.3. Member Medicaid number (Member ID);

6.8.2.1.4. Encounter date of service;

6.8.2.1.5. Eligibility category of Member (category of aid);

6.8.2.1.6. Amount billed by FQHC;

6.8.2.1.7. Third party payor (required for Members with third party coverage);

6.8.2.1.8. Third party payment amount (required for Members with third party coverage);

- 6.8.2.1.9. Third party payment or denial date (required for Members with third party coverage);
- 6.8.2.1.10. Member name (last name, first name);
- 6.8.2.1.11. Name of FQHC service location;
- 6.8.2.1.12. FQHC Medicaid Provider number;
- 6.8.2.1.13. Principal diagnosis; and
- 6.8.2.1.14. Billing Code (appropriate revenue or procedure code).
- 6.8.2.2. The Contractor shall certify all data submitted is accurate, complete and truthful based on the Contractor's best knowledge, information and belief. This certification shall be signed by either the Chief Executive Officer or the Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to, the Chief Executive Officer or Chief Financial Officer.
- 6.8.3. Reconciliation with the Contractor for FQHC Services
 - 6.8.3.1. The Department will collect the actual encounter data for the FQHC visits from the Contractor.
 - 6.8.3.2. Annually (March 1st for the previous fiscal year), the Department will reconcile the difference of the encounter payment identified in section 6.8.1.1 of this Contract.

6.9. INSPECTION OF FINANCIAL RECORDS

- 6.9.1. In addition to the Financial Reporting as outlined in 5.7, the Contractor shall allow the Department to inspect and audit the financial records of the Contractor and its Subcontractors related to this Contract.

6.10. MEDICAID PAYMENT IN FULL

- 6.10.1. Except as allowed in this Contract, the Contractor shall not, for any reason, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Member, or any persons acting on a Member's behalf, for Covered Services provided pursuant to this Contract.
- 6.10.2. Except as allowed in this Contract, the Contractor shall ensure that all of its Subcontractors and Participating Providers do not, for any reason, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Member, or any persons acting on a Member's behalf other than the Contractor, for Covered Services provided pursuant to this Contract.
- 6.10.3. This section shall not be construed to limit the ability of any of the Contractor's Subcontractors or Participating Providers to bill, charge, seek compensation, remuneration or reimbursement from or have any recourse against the Contractor for any service provided pursuant to this Contract or any other agreement entered into between that Subcontractor or Participating Provider and the Contractor.
- 6.10.4. This provision shall survive the termination of this Contract, for authorized services rendered prior to the termination of this Contract, regardless of the reason for the termination. This provision shall be construed to be for the benefit of the Contractor's Members.

- 6.10.5. As a precondition for obtaining federal financial participation for payments under this agreement, per 45 CFR Sections 95.1 and 95.7, the Department must file all claims for reimbursement of payments to the Contractor with CMS within 2 years after the calendar quarter in which the Department made the expenditure. The Contractor and the Department will work jointly to ensure that reconciliations are accomplished as required by CMS for timely filing. If the Department is unable to file the Contractor's claims or capitation payments within 2 years after the calendar quarter in which the Department made the expenditure due to inadequate or inaccurate Contractor records, and the Department does not meet any of the exceptions listed at 45 CFR Section 95.19, no claims or capitations will be paid to the Contractor for any period of time disallowed by CMS. Furthermore, the Department shall recover from the Contractor all claims and capitations paid to the Contractor for any period of time disallowed by CMS.

SECTION 7.0 ADDITIONAL FEDERAL REQUIREMENTS

7.1. FEDERAL DEBARRED ENTITIES

- 7.1.1. In addition to the Debarment and Suspension provisions in §21(C) of this Contract, the Contractor shall not knowingly have a relationship with any of the following entities:
- 7.1.1.1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- 7.1.1.2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in the prior paragraph.
- 7.1.2. For the purposes of this section, a relationship is described as:
- 7.1.2.1. A director, officer or partner of the Contractor.
- 7.1.2.2. A person or entity with more than five percent (5%) beneficial ownership of the Contractor.
- 7.1.2.3. A Person with an employment, consulting or other arrangement with the Contractor that is responsible for any of the Contractor's obligations under this Contract.
- 7.1.3. The Contractor shall not employ or contract with any Provider that is excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

7.2. FEDERAL INTERMEDIATE SANCTIONS

- 7.2.1. The Department may implement any intermediate sanctions, as described in 42 CFR 438.702, if the Department makes the determination to impose sanctions under 42 CFR 438.700.
- 7.2.2. Before imposing any intermediate sanctions, the Department shall give the Contractor timely written notice that explains:
- 7.2.2.1. The basis and nature of the sanction.

7.3. TERMINATION UNDER FEDERAL REGULATIONS

- 7.3.1. The Department may terminate this Contract for cause and enroll any Member enrolled with the Contractor in other Plan, or provide their Medicaid benefits through other options included in the State plan, if the Department determines that the Contractor has failed to:
 - 7.3.1.1. Carry out the substantive terms of its contracts.
 - 7.3.1.2. Meet applicable requirements in sections 1932, 1903(m) and 1905(t) of the Social Security Act (42 U.S.C. 401).
- 7.3.2. Before terminating the Contractor's Contract as described in this section, the Department shall:
 - 7.3.2.1. Provide the Contractor a cure notice that includes, at a minimum, all of the following:
 - 7.3.2.1.1. The Department's intent to terminate.
 - 7.3.2.1.2. The reason for the termination.
 - 7.3.2.1.3. The time and place for the pre-termination hearing
 - 7.3.2.2. Conduct a pre-termination hearing.
 - 7.3.2.3. Give the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract.
 - 7.3.2.4. If the Department determines, after the hearing, to terminate the Contract for cause, then the Department shall send a written termination notice to the Contractor that contains the effective date of the termination.
 - 7.3.2.4.1. Upon receipt of the termination notice, the Contractor shall give Members enrolled with the Contractor notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving Medicaid services following the effective date of termination.
- 7.3.3. Once the Department has notified the Contractor of its intent to terminate under this section, the Department may:
 - 7.3.3.1. Give the Members enrolled with the Contractor written notice of the Department's intent to terminate the Contract.
 - 7.3.3.2. Allow Members enrolled with the Contractor to Disenroll immediately, without cause.

7.4. TRANSITION AT TERMINATION REQUIREMENTS

- 7.4.1. Upon termination of the Contract for any reason, the Contractor shall do all of the following for a period not exceed sixty (60) days before termination of the Contract:
 - 7.4.1.1. Provide the Department with all information related to the Contractor's PCMP Network, its Members and the services provided to those Members, for transition to the Department or any other contractor of the Contractor's responsibilities.

- 7.4.1.2. Provide for the uninterrupted continuation of all network management, Care Coordination and administrative services until the transition of every member is complete and all requirements of the Contract are satisfied.
- 7.4.1.3. Designate an appropriate individual as the transition coordinator to work with the Department and any staff from the replacement contractor to ensure the transition does not adversely impact any member's care.
- 7.4.1.4. Provide to the Department all reports reasonably necessary for a transition.
- 7.4.1.5. Notify any Subcontractors of the termination of the Contract, as directed by the Department.
- 7.4.1.6. Notify all of the Members in the Contractor's Region that the Contractor will no longer be the RCCO for the region, in a form and manner approved by the Department.
- 7.4.1.7. Notify each PCMP in the Contractor's PCMP Network of the termination and the end date of the Contract and explain to the provider how the provider may continue participating in the ACC program.
- 7.4.1.8. Cooperate with the Department and any other replacement contractor during the transitions, including, but not limited to, using reasonable efforts to share and transfer Member information and following any instructions or performing any required actions, as reasonably directed by the Department.
- 7.4.1.9. Provide the Department, in a format prescribed and approved by the Department:
 - 7.4.1.9.1. A list of all PCMPs in the Contractor's PCMP Network.
 - 7.4.1.9.2. A list of all Members in the Contractor's Region.

7.5. FEDERAL DISCLOSURES OF INFORMATION ON OWNERSHIP AND CONTROL

- 7.5.1. The Contractor shall provide all disclosures required by 42 CFR 455.104, as amended or hereinafter amended, in a form substantially similar to Exhibit G, Contractor Disclosure Template. These disclosures are:
 - 7.5.1.1. The name and address of any person, either an individual or a corporation, with an ownership or control interest in the Contractor. For a corporate entity, the address shall include the primary business address, the address of each business location if there is more than one location and any applicable P.O. Box address.
 - 7.5.1.1.1. The date of birth and social security number for any individual with an ownership or control interest in the Contractor.
 - 7.5.1.1.2. The tax identification number of any corporate entity with an ownership or control interest in the Contractor or in any Subcontractor in which the Contractor has a five percent (5%) or greater interest.
 - 7.5.1.2. Whether any person, either an individual or a corporation, with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child or sibling.

- 7.5.1.2.1. Whether any person, either an individual or a corporation, with an ownership or control interest in the any Subcontractor in which the Contractor has a five percent (5%) or greater interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child or sibling.
- 7.5.1.3. The name of any other entity required to disclose under 42 CFR 455.104 in which any owner of the Contractor has an ownership or control interest.
- 7.5.1.4. The name, address, date of birth and Social Security Number of any managing employee of the Contractor.
- 7.5.2. “Ownership interest” and “person with an ownership or control interest” shall have the meaning specified in 42 CFR 455.101, as amended or hereinafter amended. “Subcontractor”, for purposes of this subsection regarding Federal Disclosures of Information on Ownership and Control only, shall have the meaning specified in 42 CFR 455.101, as amended or hereinafter amended.
- 7.5.3. The Contractor shall complete these disclosures upon execution of the Contract. The Contractor shall deliver new disclosures to the Department within thirty-five (35) days of the any change in ownership of the Contractor.

7.6. FEDERAL FINANCIAL PARTICIPATION AND FINANCIAL SOLVENCY

- 7.6.1. The Contractor shall ensure that under no circumstance shall a Member be held liable for:
 - 7.6.1.1. The Contractor’s debts, in the event of the Contractor's insolvency.
 - 7.6.1.1.1. The Contractor shall provide assurances to the Department that no Member will be held liable for the Contractor’s debts, in the event of the Contractor's insolvency.
 - 7.6.1.2. The Covered Services provided to the Member, for which the Department does not pay the Contractor.
 - 7.6.1.3. The Covered Services provided to the Member, for which the Department or the Contractor does not pay the individual or health care provider that furnishes the services under a contractual, Referral, or other arrangement.
 - 7.6.1.4. The payments for Covered Services furnished under the Contract, Referral or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly.
- 7.6.2. The Contractor shall ensure that no Member is billed by a Subcontractor or Referral Provider for any amount greater than would be owed if the Contractor provided the services directly.
- 7.6.3. The Contractor shall meet all solvency standards, established by the State of Colorado, for private health maintenance organizations.
- 7.6.4. In the event that the Contractor becomes insolvent, the Contractor shall cover continuation of services to Members for the duration of the period for which payment has been made, as well as for inpatient admissions up until discharge.

7.7. PHARMACY REBATES

- 7.7.1. The Department will collect pharmacy rebates when the Contractor submits pharmacy encounters into the Prescription Drug Card System (PDCS). The PDCS will adjudicate those pharmacy encounters submitted by the Contractor and feed all rebatable pharmacy claims into the Drug Rebate Analysis Management System (DRAMS). DRAMS will then collect the manufacturer information and generate quarterly invoices to the drug manufacturer. The drug manufacturers will pay all drug rebates to the Department, and the Contractor shall not be responsible for any of these rebates. These amounts will be totaled quarterly and reported to CMS on the CMS-64 form.

Exhibit B
COVERED SERVICES

SECTION 1.0 DEFINITIONS

- 1.1.1. **Dialysis Treatment Center:** A health institution or a department of a licensed hospital, which is planned, organized, operated and maintained to provide outpatient treatment by means of dialysis and/or training for home use of dialysis equipment.
- 1.1.2. **Durable Medical Equipment (DME)** means Medically Necessary equipment prescribed by a physician that can withstand repeated use, serves a medical purpose, and is appropriate for use outside of a medical facility.
- 1.1.3. **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
 - 1.1.3.1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
 - 1.1.3.2. Serious impairment to bodily functions.
 - 1.1.3.3. Serious dysfunction of any bodily organ or part.
- 1.1.4. **Expanded EPSDT** shall mean those services that are not explicitly provided under this exhibit but which are Medically Necessary to correct or ameliorate defects and physical or mental illnesses or conditions discovered or shown to have increased in severity by an EPSDT screening. It does not include items or services that the Department determines are not safe and cost effective or which are considered experimental.
- 1.1.5. **Family Planning** are services and supplies furnished directly (or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active), which includes physical examinations, diagnosis, treatment, supplies and follow-up.
- 1.1.6. **Habilitative Therapy Services** are services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in Colorado's EHB benchmark plan. Parity in this context means of like type and substantially equivalent in scope, amount, and duration in accordance with 45 CFR 156.110(f) and 45 CFR156.115(a)(5).
 - 1.1.6.1. Habilitative Therapy Services are only available to Expansion Members.
- 1.1.7. **Medically Necessary**, or Medical Necessity, shall be defined as a covered Medicaid service that will, or is reasonably expected to, prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury, or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs.

- 1.1.8. **Medical Screening Examination:** Screening of sick, wounded, or injured persons in the emergency room to determine whether the person has an Emergency Medical Condition. An appropriate Medical Screening Examination (including ancillary services routinely available to an emergency treatment facility) must be available to any individual who comes to the emergency treatment facility for examination or treatment of a medical condition and on whose behalf the examination or treatment is requested.
- 1.1.9. **Orthotic:** An orthopedic appliance used to support, align, prevent or correct deformities or to improve the function of movable parts of the body.
- 1.1.10. **Outpatient Services** are those diagnostic, therapeutic, rehabilitative, preventive and palliative items and services furnished by or under the direction of a physician to an eligible person who is an outpatient in a participating hospital that is not providing the patient room and board on a continuous twenty-four hour basis.
- 1.1.11. **Palliative Services** means any medical services recommended by a physician within the scope of his/her practice under state law, for the purpose of affording a recipient relief from the symptoms of a condition or disease.
- 1.1.12. **Poststabilization Care Services** means Covered Services, related to an Emergency Medical Condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition to improve or resolve the enrollee's condition, as set forth at 42 CFR §422.113.
- 1.1.13. **Preventive Services:** Services provided by a physician within the scope of his/her practice under state law to:
- 1.1.13.1. Prevent disease, disability, and other health conditions or their progression;
 - 1.1.13.2. Prolong life; and,
 - 1.1.13.3. Promote physical and mental health and efficiency.
- 1.1.14. **Prosthetic Device:** replacement, corrective or supportive devices prescribed by a doctor of medicine or a doctor of osteopathy to:
- 1.1.14.1. Artificially replace a missing portion of the body
 - 1.1.14.2. Prevent or correct physical deformity or malfunction
 - 1.1.14.3. Support a weak or malformed portion of the body
- 1.1.15. **Rehabilitative Services:** Any medical or remedial services recommended by a physician within the scope of his/her practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his/her best possible functional level.
- 1.1.16. **Speech Pathologist:** Person specializing in the diagnostic evaluation and treatment of speech and language problems; the planning, directing or conducting of habilitative or rehabilitative treatment programs to restore communicative efficiency of communication problems or organic and non-organic etiology; provision of counseling and guidance for speech and language handicaps.

- 1.1.17. **Telemedicine** is defined as the delivery of medical services, and any diagnosis, consultation, treatment, transfer of medical data, or education related to health care services using interactive audio, interactive video, or interactive data communication instead of in-person contact.
- 1.1.18. **Therapeutic Services** means any medical service provided by a physician within the scope of his/her practice of medicine under state law, in the treatment of disease.

SECTION 2.0 COVERED SERVICES

2.1. With the exception of EPSDT and preventive services as specified in this exhibit, covered services and supplies must be medically necessary and provided for the diagnosis or treatment of an illness, pregnancy, or accidental injury. A covered person and his or her physician decide which services and supplies are given, but contractors need only pay for the following covered services and supplies.

2.1.1. Abortion

2.1.1.1. Abortions are a Covered Service only in the following circumstances:

2.1.1.1.1. When a physician has found and certified in writing that in his or her professional judgment the life of the mother would be endangered if the fetus were carried to term, when documented in accordance with federal requirements. 42 C.F.R. § 441.203.

2.1.1.1.2. If the pregnancy is a result of rape or incest.

2.1.1.2. NOTE: For the purpose of this section, treatment for the following conditions is not considered to be an abortion:

2.1.1.2.1. Ectopic pregnancies (Pregnancy occurring in other than a normal position or place); and

2.1.1.2.2. Miscarriage (spontaneous abortion).

2.1.2. Ambulance Services

2.1.2.1. Covered ambulance services shall be provided to the nearest appropriate medical facility when any other form of transportation is not medically advisable and when the ambulance service is provided in conjunction with emergency medical care. Such covered ambulance services include the following situations:

2.1.2.2. Air ambulance

2.1.2.2.1. Air ambulance services, including rotary- and fixed-wing aircraft, are covered only if the client requires medical attention, the client is transported to the nearest appropriate medical facility, and

2.1.2.2.1.1. The point of pickup is inaccessible by land emergency transport vehicles,

2.1.2.2.1.2. Great distances or other obstacles are involved in transport to the nearest appropriate facility and prompt admission is essential; or

2.1.2.2.1.3. The client is suffering from an illness, injury, or psychiatric condition that makes all other forms of transport inadvisable.

- 2.1.2.2.2. Emergency Services which, due to the medical or psychiatric condition of the Client, are immediate in nature and cannot be arranged in advance.
- 2.1.2.2.3. Non-emergency Services that are preplanned but due to the medical or psychiatric condition of the Client are the only mode that can be utilized safely. Must be prior authorized.
- 2.1.2.3. If the Client is transported from home to hospital by ambulance for treatment of a condition which a prudent layperson would perceive as an emergency, as defined at 10 CCR 2505-10 Section 8.303, the ambulance shall be reimbursed, even if the healthcare services rendered are subsequently determined to be urgent or non-emergent in nature. 42 C.F.R. 438.114 (c) (1) (ii).
- 2.1.3. **Ambulatory surgical care**
- 2.1.3.1. The allowable surgical procedures identified for Medicare coverage are reimbursable and covered Medicaid benefits.
- 2.1.4. **Amniocentesis**
- 2.1.4.1. Amniocentesis performed for medical reasons other than sex determination.
- 2.1.5. **Anesthesia Services**
- 2.1.5.1. Administration of anesthetics to achieve general, regional or supplementation of local anesthesia related resuscitative and supportive procedures.
- 2.1.6. **Audiology and Speech Pathology**
- 2.1.6.1. Audiological services include medical/diagnostic ear testing using recognized diagnostic instrumentation/equipment in a clinical environment to assist or confirm in establishing a diagnosis.
- 2.1.6.2. Speech pathology services include performance of medical/diagnostic procedures including, but not limited to, those communicative problems resulting from medical conditions such as cerebral palsy, cleft palate/lip, or brain dysfunction.
- 2.1.6.3. NOTE: The EPSDT benefit covers screening and Medically Necessary ear exams and audiological testing.
- 2.1.7. **Autism**
- 2.1.7.1. Autism shall be treated as a physical disorder.
- 2.1.8. **Consultation**
- 2.1.8.1. Covered Services include medical services rendered by a provider whose opinion or advice is requested by a Client's primary care provider or the health plan medical director for further evaluation of an illness or injury. Clients shall be granted a second opinion when requested, subject to referral requirements. Consultations by non-participating providers may be subject to prior authorization.
- 2.1.9. **Detoxification**
- 2.1.9.1. Includes detoxification for withdrawal from the physiological effects of acute alcohol or drug abuse.
- 2.1.10. **Dialysis, Hemodialysis or Peritoneal Dialysis**

- 2.1.10.1. Coverage includes placement or repair of the dialysis route (“shunt” or “cannula”).
- 2.1.10.2. The organization providing dialysis shall be responsible for the provision of all supplies and the maintenance of all equipment and necessary fixtures required for home dialysis.
 - 2.1.10.2.1. Inpatient dialysis
 - 2.1.10.2.1.1. Coverage is provided in those cases where hospitalization is required.
 - 2.1.10.2.2. Outpatient dialysis
 - 2.1.10.2.2.1. Coverage is provided when provided by a separate unit within a hospital or a freestanding Dialysis Treatment Center. Coverage is provided for any other medical condition for which the Medical Assistance Program provides payment when the eligible recipient receives regular Medically Necessary maintenance treatment on an outpatient dialysis program.
 - 2.1.10.2.3. Home dialysis
 - 2.1.10.2.3.1. The participating separate dialysis unit within a hospital or free-standing Dialysis Treatment Center shall be responsible for the maintenance of all equipment and necessary fixtures required for home dialysis and provisions of all supplies.
- 2.1.11. **Durable Medical Equipment and Disposable Supplies**
 - 2.1.11.1. The following Durable Medical Equipment (DME) and supplies are Medicaid benefits for clients of all ages if Medical Necessity has been established and use outside of a medical facility is considered appropriate. DME shall be covered as described at 10 CCR 2505-10, Section 8.590.
 - 2.1.11.1.1. Ambulation devices & accessories (canes, crutches, walkers),
 - 2.1.11.1.2. Bath and bathroom equipment,
 - 2.1.11.1.3. Bed and bedroom equipment and accessories, including specialized beds and mattress overlays,
 - 2.1.11.1.4. Manual or power wheelchairs, seating system orthosis used for wheelchair positioning,
 - 2.1.11.1.5. Diabetic monitoring equipment and related disposable supplies,
 - 2.1.11.1.6. Elastic supports/stockings,
 - 2.1.11.1.7. Monitoring equipment and supplies,
 - 2.1.11.1.8. Oxygen Equipment for home use, including nursing facility residents, See Exclusions
 - 2.1.11.1.9. Transcutaneous and/or neuromuscular electrical nerve stimulators (tens) and related supplies
 - 2.1.11.1.10. Trapeze/traction/fracture frames,
 - 2.1.11.1.11. Lymphedema pumps/compressors,
 - 2.1.11.1.12. Rehabilitation equipment (specialized use),

- 2.1.11.1.13. Enteral formulas and supplies,
- 2.1.11.1.14. Parenteral equipment and supplies, and
- 2.1.11.1.15. Repairs and extensive maintenance as needed to keep the DME item functional.
- 2.1.11.2. The contractor shall provide an adequate number of disposable supplies when used in connection with approved DME and/or when related to one of the following categories:
 - 2.1.11.2.1. Surgical, wound and burn care,
 - 2.1.11.2.2. Syringes/needles,
 - 2.1.11.2.3. Bowel and bladder care,
 - 2.1.11.2.4. Antiseptics/solutions,
 - 2.1.11.2.5. Gastric feeding sets and supplies,
 - 2.1.11.2.6. Tracheostomy and endotracheal care supplies, or
 - 2.1.11.2.7. Diabetic monitoring.
- 2.1.11.3. Covered Services include the rental or purchase of DME and supplies including repair, maintenance and delivery. The Contractor is only required to provide DME that is covered by Medicaid, but may provide other DME when medically appropriate. Preference should be given to items with demonstrated strength, durability, ease of use and appropriateness for the Client and for conditions under which the equipment will be operated. Coverage in a particular case is subject to the requirement that the equipment be Medically Necessary for treatment of an illness, injury, condition, secondary disability, or for maintenance of health. DME and supplies may be recommended by an appropriate licensed practitioner, but must be prescribed by a doctor of medicine or a doctor of osteopathy.
- 2.1.11.4. Medicaid clients for whom wheelchairs, wheelchair component parts, and other specialized equipment were authorized and ordered prior to enrollment in the Contractor's Plan, but for which delivery is delayed until after the HMO enrollment period begins, shall have those services provided by the Medicaid Program. The Contractor shall reimburse services approved and ordered by the Contractor providing the client remains Medicaid eligible, regardless of whether enrollment in the Plan continues. All other DME and disposable supplies approved by the Contractor shall be the responsibility of the Contractor.
- 2.1.12. **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Benefits**
 - 2.1.12.1. The Contractor must meet all state and federal requirements for EPSDT benefits under 42 C.F.R. Sections 441.50 through 441.61 and 10 C.C.R. 2505-10, Section 8.280. EPSDT services include comprehensive well child examinations, immunizations, assessment, diagnosis and treatment necessary to correct or ameliorate conditions, defects and illnesses discovered by EPSDT screening to all covered persons through the age of 20. EPSDT services also include provision benefit information, scheduling assistance and case management.
 - 2.1.12.2. Information about EPSDT benefits must be provided to clients and parents, to include:

- 2.1.12.2.1. Information about the periodicity table,
- 2.1.12.2.2. Scheduling and transportation to make EPSDT appointments, and
- 2.1.12.2.3. Information about the full range of EPSDT wraparound benefits and mental health treatment services available through State Medicaid.
- 2.1.12.3. Additionally, maintenance of a coordinated system to follow the client through the entire range of screening and treatment (case management) and coordination with other providers to ensure that clients receive Covered Services, must be provided.
- 2.1.13. **Emergency Services**
- 2.1.13.1. Emergency Services means covered inpatient and Outpatient Services that are as follows:
 - 2.1.13.1.1. Furnished by a provider that is qualified to furnish these services under this Contract; and
 - 2.1.13.1.2. Needed to evaluate or stabilize an Emergency Medical Condition.
- 2.1.13.2. Emergency services are exempt from Primary Care Provider referral.
- 2.1.14. **Family Planning Services**
- 2.1.14.1. Family Planning counseling, examination, treatment and follow-up; information on birth control (including insertion and removal of approved contraceptive devices); measurement for contraceptive diaphragms; and male/female surgical sterilization (see Surgical Services, Sterilization) is included even if the Member goes out of network. The fees are included in the rates. The Contractor shall reimburse out-of-network family planning services at a rate equal to Medicaid fee-for-service reimbursement rates, or the Contractor's contractual reimbursement rates, whichever is higher. No referral is required.
- 2.1.15. **Federally Qualified Health Care (FQHC)**
- 2.1.15.1. Core services are provided in outpatient settings only, including a Member's place of residence. Core services means covered Outpatient Services that may include:
 - 2.1.15.1.1. Physician services;
 - 2.1.15.1.2. Physician assistant services;
 - 2.1.15.1.3. Nurse practitioner services;
 - 2.1.15.1.4. Nurse midwife services;
 - 2.1.15.1.5. Licensed psychologist services;
 - 2.1.15.1.6. Licensed social worker services;
 - 2.1.15.1.7. Pneumococcal and influenza vaccines and administration;
 - 2.1.15.1.8. Services and supplies incident to health professional services;
 - 2.1.15.1.9. Part-time or intermittent nursing care and related medical supplies to a homebound individual, in the case of those FQHCs that are located in an area that is determined to have a shortage of home health agencies; and

- 2.1.15.1.10. Any other reimbursable ambulatory services offered by the FQHC that are covered by the State Plan.
- 2.1.15.2. Notwithstanding a BHO primary diagnosis, services provided to Members by a physician (not a mental health practitioner) are covered (and have been included in the rates). The BHO diagnosis code is attached as Exhibit F.
- 2.1.16. **Habilitative Health Services**
 - 2.1.16.1. Habilitative therapy services shall have parity in amount, scope, and durations to rehabilitative therapies and will only consist of physical, occupational, and speech-language therapy services.
 - 2.1.16.2. The procedure code set for Habilitative therapies is identical to that of Rehabilitative therapies.
 - 2.1.16.3. All Habilitative Therapy Services require prior authorization.
 - 2.1.16.4. Habilitative Therapy is only available to Expansion Members.
- 2.1.17. **Home Health Services**
 - 2.1.17.1. Upon enrollment, the contractor shall provide Acute Home Health Services as defined in 10 CCR 2505-10. Section 8.520. Members eligible for Acute Home Health Services must be eligible for services as set forth at 10 CCR 2505-10, Section 8.520. The contractor is not required to cover more than one nurse, home health aide or therapist at one time except when two aides are required for transfers or more than one nurse is needed to perform a procedure.
 - 2.1.17.2. Services provided by other kinds of providers (i.e. other than a Medicaid-certified Home Health agency) to Members in their own homes are also Covered Services and are included in the capitation rates. These kinds of Covered Services include:
 - 2.1.17.2.1. Professional services of an RN, LPN or LVN on an intermittent basis
 - 2.1.17.2.2. Home health aide services for purposes of providing skilled personal care, in conjunction with a nurse or therapist and under the supervision of a nurse or therapist
 - 2.1.17.2.3. Physical evaluations and therapy, and speech/hearing evaluations and therapy, occupational therapy by licensed therapists.
 - 2.1.17.2.4. Medical/surgical supplies delivered to the Member's home (e.g. DME, prosthetics, disposable supplies), but not other Wrap Around services.
 - 2.1.17.2.5. Services provided when the Member's medical condition requires teaching (e.g. self-care management training), which is most effectively accomplished in the Client's home on a short-term basis.
 - 2.1.17.2.6. Developmental therapies and EPSDT screenings (e.g. Neuromuscular reeducation, Sensory integration, Cognitive skills development).
 - 2.1.17.3. Nurse Home Visitor Program services provided in the Member's home are Wrap Around services. These services are billed on the 1500 claim form using CPT codes G9006 or T1017.
- 2.1.18. **Imaging (Radiology or X-ray Services)** Services authorized by a licensed physician.

- 2.1.18.1.1. Services performed to diagnose conditions and illnesses with specific symptoms.
- 2.1.18.1.2. Services are performed to prevent or treat conditions that are reimbursable under the Medical Assistance Program.
- 2.1.18.1.3. Routine mammograms as described under Preventative Care Services.
- 2.1.19. **Inpatient Hospital**
- 2.1.19.1. Hospital services are a benefit of the Medicaid Program and include those items and services that are ordinarily furnished by a hospital for the care and treatment of inpatients provided under the direction of a physician.
 - 2.1.19.1.1. Semi-Private Room and Board
 - 2.1.19.1.2. Private rooms must be covered:
 - 2.1.19.1.2.1. When Medically Necessary
 - 2.1.19.1.2.2. When furnished by the hospital as the only accommodation
 - 2.1.19.1.2.3. If the hospital has no semi-private room available. Member must be moved to a semi-private room as soon as available.
 - 2.1.19.1.3. Delivery and labor rooms, anesthesia, and equipment.
 - 2.1.19.1.3.1. Limitations for a hospital stay following a normal vaginal delivery may be limited after 48 hours post delivery.
 - 2.1.19.1.3.2. Limitations for a hospital stay following a cesarean delivery may be limited after 96 hours post delivery.
 - 2.1.19.1.4. All other Medically Necessary services and supplies during the inpatient hospital stay including pharmacy, therapies, blood and blood products, anesthetics, Durable Medical Equipment (DME) and specialty care services.
 - 2.1.19.1.5. Discharge oxygen
 - 2.1.19.1.6. Routine Newborn care is limited to period of time that the mother remains hospitalized and is billed under the Mother's Medicaid Client ID. Inpatient newborn care following the mother's discharge is not a covered benefit under this Contract. The newborn will receive its own Medicaid Client ID retrospective to its date of birth and will be billed FFS.
 - 2.1.19.1.7. Inpatient substance abuse rehabilitation DRG 936 is a wrap around. See Wrap Around Benefits Section.
- 2.1.20. **Laboratory (clinical/pathological)**
- 2.1.20.1. Services authorized by a licensed physician.
 - 2.1.20.1.1. Services performed to diagnose conditions and illnesses with specific symptoms.
 - 2.1.20.1.2. Services performed to prevent or treat conditions that are reimbursable under the Medical Assistance Program.

2.1.20.2. Services performed by a certified laboratory in accordance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

2.1.20.3. **LIMITATIONS**

2.1.20.3.1. Collection, handling, and/or conveyance of specimens for transfer from the member's home, a nursing home or a facility other than the physician's office or place of practice is a benefit only if the member is homebound, bedfast, or otherwise non-ambulatory. However, when a specimen of this type could be reasonably mailed, the pickup is no longer considered Medically Necessary and therefore is non-reimbursable. The physician may be required to certify the Medical Necessity for the pick-up. Transfer of a specimen from one certified independent clinical laboratory to another is a benefit and reimbursable to the first certified laboratory only if the laboratory's equipment is not functioning or the laboratory is not certified to perform the tests ordered by the physician.

2.1.21. **Medical Services**

2.1.21.1. For specific procedures and indications of basic Medicaid coverage, the Medicaid Master Procedure File as published in Provider bulletins or available on disc shall be considered the prevailing guide. The following is a general overview of such services.

2.1.21.1.1. Direct physical examination of the member's body and/or mental or cognitive status.

2.1.21.1.2. Examination of some aspect of the member's condition by means of radiological, non-radiological diagnostic imaging, pathology, laboratory or electronic monitoring procedures.

2.1.21.1.3. Procedures for prescribing, administering, directing or supervising medical treatment.

2.1.21.1.4. Manual manipulation. Department guidelines, which include manipulation by osteopathic physicians only, may be applied by the Plan.

2.1.21.1.5. Diagnosis and treatment of eye disease or injury.

2.1.21.1.6. Administration of injectables and allergens.

2.1.21.1.7. Counseling: Diet and/or nutritional counseling when the diagnosis indicates or includes a clinical problem that is or could be impacted by obesity.

2.1.21.1.8. Treatment for ear or hearing problems.

2.1.22. **Newborn Hospitalization**

2.1.22.1. Newborn hospitalizations shall extend only for the period of the mother's hospitalization unless Medical Necessity exists for the newborn to remain hospitalized. If Medical Necessity for the newborn to remain hospitalized exists, the additional days shall be billed FFS.

2.1.23. **Occupational/Physical Therapy**

2.1.23.1. A physician may prescribe occupational or physical therapy for clients when Medically Necessary.

2.1.24. **Outpatient Services**

2.1.24.1. Covered Services include diagnostic, Therapeutic, Rehabilitative, Preventive, and Palliative Services furnished by or under the direction of a physician.

2.1.25. **Outpatient Rehabilitation Services**

2.1.25.1. Covered Services include speech therapy, occupational therapy, physical therapy, pulmonary therapy and cardiac rehabilitation when ordered by the Covered Person's Primary Care or Referring Physician.

2.1.25.2. All Medically Necessary care and treatment of conditions discovered as a result of EPSDT medical screenings, including habilitation secondary to birth injury or developmental delay and rehabilitation services following illness or injury, shall be provided to Clients covered by the EPSDT Program.

2.1.26. **Oxygen and Oxygen Equipment**

2.1.26.1. Oxygen and oxygen equipment in a clients home, or place used as his/her home, and prescribed by the attending physician, is covered. Any form of oxygen for use by clients in an inpatient hospital setting must be provided by the hospital. The nursing facility must provide all forms of oxygen except for liquid or gaseous oxygen and the supplies and equipment necessary to administer each.

2.1.27. **Physical examinations**

2.1.27.1. Physical examinations for the purpose of:

2.1.27.1.1. Diagnostic evaluation of disease, and

2.1.27.1.2. Admission or placement in skilled nursing home care, intermediate nursing home care, residential care, or early and periodic screening, diagnosis and treatment.

2.1.28. **Physical/Occupational Therapy**

2.1.28.1. Occupational or physical therapy for clients when Medically Necessary and ordered by a physician.

2.1.29. **Physician Services**

2.1.29.1. Age 65 and over: All Medically Necessary services.

2.1.29.2. Under the age of 65: the following scope and range of benefits when Medically Necessary:

2.1.29.2.1. Inpatient hospital services

2.1.29.2.2. Inpatient surgery

2.1.29.2.3. Outpatient surgery

2.1.29.2.4. Outpatient diagnostic services

2.1.29.2.5. Physician services provided to residents in a skilled nursing facility

2.1.29.2.6. Home and physician office calls

- 2.1.29.2.7. Family Planning is considered in the same manner as for any other medical visit. Services provided in connection with medication and devices to be employed are supplied for the purpose of Family Planning, depending on the preference of the individual recipient/member. See Family Planning under Covered Services.
- 2.1.29.2.8. Dental care is a benefit when provided for surgery related to the jaw or any structure contiguous to the jaw or reduction of fracture of the jaw or facial bones, including dental splints or other devices. With respect to these services, a doctor of dental surgery or dental medicine, appropriately licensed, is classified as a physician and entitled to payment.
- 2.1.29.2.9. Foot care services
- 2.1.29.2.10. Vision care services are included as benefits in accordance with the following general policies:
 - 2.1.29.2.10.1. Services performed within the scope of the Medical and Optometrist Practice Acts
 - 2.1.29.2.10.2. Services for the provision of eyeglasses and contact lenses following eye surgery.
 - 2.1.29.2.10.3. Corneal transplants
- 2.1.29.2.11. Services in regard to laboratory testing in accordance with the Imaging and Laboratory sections of this exhibit
- 2.1.29.2.12. Immunizations
- 2.1.30. **Podiatry**
 - 2.1.30.1. Foot care services are included as a benefit in the Medical Assistance Program whether provided by a physician or licensed podiatrist.
- 2.1.31. **Prescription Drugs**
 - 2.1.31.1. The Contractor is responsible for prescription drugs.
- 2.1.32. **Preventive Medicine**
 - 2.1.32.1. Examinations for the purpose of diagnosis and treatment of existing illness or injury are not included in this section. The client and the primary care physician will determine exam periodicity for members with a disability.
 - 2.1.32.2. Physical exams
 - 2.1.32.2.1. Under age 21, see Early Periodic Screening, Diagnosis and Treatment (EPSDT)
 - 2.1.32.2.2. Age 21 - 35, at least once every 5 years but not more than once a year
 - 2.1.32.2.3. Age 36 - 50, at least once every 2 years but not more than once a year
 - 2.1.32.2.4. Over age 50, once every 12 months
 - 2.1.32.3. Women's health
 - 2.1.32.3.1. Routine yearly breast and pelvic examination with PAP smear, hematocrit and urinalysis

- 2.1.32.3.2. Routine mammograms as required by statute (Section 10-16-104 C.R.S.): a single baseline mammogram for women from age 35 to 39; at least once every two contract years for women from age 40 to 49, except women with risk factors to breast cancer, as determined by the primary care physician, shall be at least once per year; and at least once per contract year for women age 50 to 65 years.
- 2.1.32.4. Men's Health
 - 2.1.32.4.1. Age 40 to 50 in high-risk categories (as determined by the primary care physician), in accordance with statute (Section 10-16-104 C.R.S.)
 - 2.1.32.4.2. Age 50 years and older, screening for early detection of prostate cancer at least once per year.
- 2.1.32.5. Health education services
 - 2.1.32.5.1. Instruction in personal health care measures, including those appropriate for clients with disabilities;
 - 2.1.32.5.2. Instruction for a designated client representative, when the client is unable to receive or understand such services due to a disability;
 - 2.1.32.5.3. Information about services, including recommendations on generally accepted medical standards for use and frequency of such service.
- 2.1.32.6. Contingent on Federal Approval from the Centers for Medicare & Medicaid, the contractor must provide preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults. Documentation is available to support claiming of FMAP for such services. As changes are made to the USPSTF and/or ACIP, coverage and billing codes will be updated to comply with the changes. Cost sharing cannot be applied to any of these services.
- 2.1.33. **Prosthetics and Orthotics**
 - 2.1.33.1. The following Prosthetic Devices and Orthotics, including but not limited to the following list, are Medicaid benefits for clients of all ages if Medical Necessity has been established and use in the home setting has been determined to be appropriate. Medical Necessity shall be determined based on criteria established by the Department, and in accordance with 10 CCR 2505-10, Section 8.590.2A:
 - 2.1.33.1.1. Ankle-foot/knee-ankle-foot Orthotics
 - 2.1.33.1.2. Artificial limbs
 - 2.1.33.1.3. Augmentative communication devices and communication boards
 - 2.1.33.1.4. Colostomy (and other ostomy) bags and necessary accouterments required for attachment, including irrigation and flushing equipment and other items/supplies directly related to ostomy care
 - 2.1.33.1.5. Facial prosthetics
 - 2.1.33.1.6. Lumbar-sacral orthoses (LSO)

- 2.1.33.1.7. Orthopedic footwear, including shoes, related modifications, inserts and heel/sole replacements when an integral part of a leg or ankle brace
- 2.1.33.1.8. Recumbent ankle positioning splints
- 2.1.33.1.9. Rigid and semi-rigid braces
- 2.1.33.1.10. Specialized eating utensils and other Medically Necessary activities of daily living aids; and
- 2.1.33.1.11. Therapeutic shoes
- 2.1.33.1.12. Thoracic-lumbar-sacral orthoses (TLSO)
- 2.1.33.2. Covered Services include the rental or purchase of Prosthetic Devices and supplies including repair, maintenance and delivery. Preference will be given to items with demonstrated strength, durability, ease of use and appropriateness for the Client and for conditions under which the devices will be operated. Coverage in a particular case is subject to the requirement that the devices be Medically Necessary for treatment of an illness, injury, condition, secondary disability, or for maintenance of health. Prosthetic Devices may be recommended by an appropriate licensed practitioner, but must be prescribed by a doctor of medicine or a doctor of osteopathy.
- 2.1.34. **Radiology – see Imaging**
- 2.1.35. **Radiation Therapy**
- 2.1.36. **Rural Health Clinics (RHC)**
 - 2.1.36.1. All of the following are benefits of the program when provided by a rural health clinic that has been certified in accordance with 10 CCR 2505-10 8.740 insofar as these services provided are otherwise reimbursable under the Program.
 - 2.1.36.1.1. Services furnished by a physician.
 - 2.1.36.1.2. Services furnished by a physician assistant, nurse practitioner, or nurse midwife, under the medical supervision of a physician.
 - 2.1.36.1.3. Services and supplies that are furnished as an incident to professional services under (2.1.36.1.1.) and (2.1.36.1.2) above.
 - 2.1.36.1.4. Part-time or intermittent visiting nurse care and related medical supplies (other than pharmaceuticals).
 - 2.1.36.1.5. Other ambulatory service that are otherwise a benefit of the program that meets specific programmatic requirements for the furnishing of that service. Such services are not subject to physician supervision requirements unless such supervision is generally required for such services under the Medicaid program.
 - 2.1.36.1.6. EPSDT services furnished by a rural health clinic that are not part of rural health clinic services. Such services may be provided only if the clinic meets any supervision or other requirements for EPSDT that are generally applicable wherever these services are furnished.
- 2.1.37. **Speech Pathology (see Audiology and Speech Pathology)**
- 2.1.38. **Substance Abuse**

2.1.38.1. Includes detoxification for withdrawal from the physiological effects of acute alcohol or drug abuse.

2.1.39. **Surgical Services**

2.1.39.1. For specific procedures and indications of basic Medicaid coverage, the Medicaid Master Procedure File shall be considered the prevailing guide.

2.1.39.1.1. Reconstructive surgery

2.1.39.1.1.1. Medically Necessary reconstructive plastic surgery or surgery to correct disfigurement resulting from trauma or affecting function, regardless of when the injury, illness or defect occurred; or

2.1.39.1.1.2. Reconstructive services following mastectomy, subject to prior approval.

2.1.39.1.2. Male genital system

2.1.39.1.3. Female genital system

2.1.39.1.4. Oral Surgical Services (limited to treat certain conditions, as follows):

2.1.39.1.4.1. Accidental injury to jawbones or surrounding tissues;

2.1.39.1.4.2. Correction of non-dental pathophysiological condition which has resulted in a severe functional impairment, including temporomandibular disorder; or

2.1.39.1.4.3. Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof, floor of mouth.

2.1.39.1.5. Sterilization

2.1.39.1.5.1. Stipulations: In order to receive sterilization services, the following criteria must be met:

2.1.39.1.5.1.1. The client must be at least 21 years of age;

2.1.39.1.5.1.2. The client may not be currently institutionalized for the care and treatment of mental illness;

2.1.39.1.5.1.3. He or she must be mentally competent;

2.1.39.1.5.1.4. The MED 178 consent form, as utilized by the Medicaid Program, must be properly signed at least 30 but no more than 180 days prior to performance of the procedure. In the case of premature delivery or emergency abdominal surgery performed within 30 days of consent, the physician must certify that the sterilization was performed less than 30 days, but more than 72 hours after informed consent was obtained because of premature delivery or emergency abdominal surgery and (1) in the case of premature delivery, must state the expected date of delivery; or (2) in the case of abdominal surgery, must describe the emergency.

2.1.40. **Tobacco Cessation**

2.1.40.1. Includes all FDA approved prescription medications and over-the-counter tobacco cessation products for a maximum of two 90-day sessions in a 12-month period, commencing upon beginning the first session. Tobacco Cessation benefit does not include any group or individual counseling services. Group or individual counseling services and all FDA approved prescription medications and over-the-counter-tobacco cessation products related to Tobacco Cessation are available for pregnant women as a wrap-around benefit.

2.1.41. Telemedicine

2.1.41.1. No Medicaid managed care organization, on or after January 1, 2002, may require face-to-face contact between a provider and a client for services appropriately provided through Telemedicine if the client resides in a county with a population with one hundred fifty thousand residents or fewer and if the county has the technology necessary for the provision of Telemedicine. The use of Telemedicine is not required when in-person care by a participating provider is available to an enrolled client within a reasonable distance.

2.1.41.2. Any health benefits provided through Telemedicine shall meet the same standard of care as in-person care.

2.1.42. Transplant Services

2.1.42.1. Includes services received in connection with bone, bone marrow/stem cell, cornea, heart, lung, heart-lung, kidney, liver (including living donor or partial liver), pancreas after kidney, simultaneous pancreas-kidney, skin:

2.1.42.1.1. Charges for retrieval or harvest of donor organs or bone marrow, if not provided by any other health care program or insurance, including any necessary compatibility testing and donor search.

2.1.42.1.2. Living donor transplant: Contractor is required to cover services to donor for costs directly related to the transplant. Services required due to complications or non-related care will be the responsibility of the donor's carrier.

2.1.42.1.3. Immunosuppressive drugs as supportive therapy for the transplant.

2.1.43. Vision Services

2.1.43.1. Under age 21, see EPSDT.

2.1.43.2. Age 21 and over: Clients with certain medical conditions and/or disabilities such as diabetes, retinal dysplasia or glaucoma may require more frequent exams, which shall be determined by the primary care physician.

2.1.43.2.1. Eye exams

2.1.43.2.1.1. One refraction once during any twenty four month period for adults age 21 to 47;

2.1.43.2.1.2. One refraction each 12 months for adults age 48 or older;

2.1.43.2.2. Vision correction: one pair of corrective lenses and no less than the Medicaid allowable contribution for frames ordered as a result of the covered examinations.

- 2.1.43.3. NOTE: The Contractor may require completion of six (6) continuous months of enrollment before providing vision benefits for adults age 21 years and older.

SECTION 3.0 EXCLUSIONS:

- 3.1.** The following services are excluded from coverage:
- 3.1.1. **Acupuncture**
 - 3.1.2. **Air ambulance services** when a Client could be safely transported by ground ambulance or by means other than ambulance.
 - 3.1.3. **Ambulatory surgical procedures** not listed on the state approved list.
 - 3.1.4. **Ambulance services** when a Client could be safely transported by means other than ambulance.
 - 3.1.5. **Audiology and Speech Pathology:** With the exception of EPSDT Covered Services, diagnostic procedures performed for the purposes of determining general hearing levels, screening, or for the distribution of a hearing device are not covered. Hearing aids are not covered under this Contract but may be provided to children under the age of 21 through the Health Care Program for Children with Special Needs. Simple articulation or academic difficulties that are not medical or surgical in origin are also excluded.
 - 3.1.6. **Autopsy charges**
 - 3.1.7. **Biofeedback**, stress management, behavioral testing and training, and counseling for sexual dysfunction.
 - 3.1.8. **Chiropractic services** unless Medicare has paid as primary and diagnostic imaging has shown the condition to be subluxation.
 - 3.1.9. **Cosmetic Procedures** or corrective plastic surgery performed solely to improve appearance. Cosmetic surgery exclusions include, but are not limited to, surgery for sagging or extra skin, any augmentation procedures, rhinoplasty and associated surgery, and any procedures utilizing an implant which does not alter physiologic functions, unless Medically Necessary and/or to correct disfigurement.
 - 3.1.10. **Counseling** for the care or treatment of marital or family problems; social, occupational, religious, or other social maladjustments; behavioral disorders or chronic situational reactions.
 - 3.1.11. **Dental services:**
 - 3.1.11.1. Dental prosthesis, or any treatment on or to the teeth, gums, or jaws and other services customarily provided for by a dentist.
 - 3.1.11.2. For adults, surgical correction of malocclusion, maxillofacial orthognathic surgery, oral surgery (except as otherwise provided under the Surgical Services), orthodontia treatment and procedures involving osteotomy of the jaw including hospital outpatient or ambulatory, anesthesia and related costs resulting from the services when determined by the Contractor to relate to a dental condition.

- 3.1.12. **Durable Medical Equipment** to include wheelchair lifts for vans or automobiles, hot tubs, Jacuzzis, exercise bikes or equipment, treadmills, stair glides, ramps for use with vehicles or homes, memberships in health clubs, or fees for swimming or other exercise or activities.
- 3.1.13. **EPSDT services** not provided under this Contract are:
 - 3.1.13.1. Hearing aids and auditory training.
 - 3.1.13.2. Psychiatric/psychological care that is included and covered through the Mental Health Capitation Program. Community Mental Health Centers formally known as Mental Health Assessment and Service Agencies (MHASAs) are required to cover diagnoses and services as described at 10 CCR 2505-10 §8.212.
 - 3.1.13.3. Services that are experimental, not safe or cost effective, or services provided for the convenience of the caregiver need not be covered.
 - 3.1.13.4. Expanded EPSDT services.
- 3.1.14. **Experimental** or investigational services or pharmaceuticals.
 - 3.1.14.1. Any treatment, procedure, drug or device that has been reviewed and found by the Department to be experimental or investigational or the treatment, procedure, drug or device has been reviewed by the Contractor and found not to meet all of the eligible for coverage criteria below with respect to the particular illness or disease to be treated, or a treatment, procedure, drug or device. Eligible for coverage criteria include:
 - 3.1.14.1.1. The treatment, procedure, drug or device must have final approval from the Food and Drug Administration (FDA), if applicable;
 - 3.1.14.1.2. The scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the treatment, procedure, drug or device on health outcomes;
 - 3.1.14.1.3. The treatment, procedure, drug or device must improve or maintain the net health outcome;
 - 3.1.14.1.4. The treatment, procedure, drug or device must be as beneficial as any established alternative; and
 - 3.1.14.1.5. The improvements in health outcomes must be attainable outside the investigational settings.
 - 3.1.14.1.6. Additionally, the treatment, procedure, drug or device must be Medically Necessary and not excluded by any other Contract exclusion.
- 3.1.15. **Government-sponsored care**
 - 3.1.15.1. Items and services provided by federal programs, such as a Veteran's Hospital.
 - 3.1.15.2. Services provided in facilities that serve a specific population, such as prisoners.
 - 3.1.15.3. Care for conditions that federal, state, or local laws require to be treated in a public facility.

- 3.1.15.4. Services for which treatment is provided under any government law now existing or subsequently enacted or amended, including but not limited to Workmen's Compensation Act, Employer Liability Law or Colorado "No-Fault" automobile insurance.
- 3.1.16. **Fertility procedures or services** that render the capability to produce children, except when that capability is a side effect of Medically Necessary surgery for another purpose/diagnosis.
- 3.1.17. **FQHC Services:** Inpatient hospital stays are not covered under FQHC Services but may be a benefit under Inpatient Hospital Care.
- 3.1.18. **HCBS Services.** Includes wrap around services such as case management (for Model 200 children), home modification, electronic monitoring, personal care, non-medical transportation & all other waiver services.
- 3.1.19. **Hearing Aids** - With the exception of EPSDT Covered Services, diagnostic procedures performed for the purposes of determining general hearing levels, screening, or for the distribution of a hearing device are not covered. Hearing aids, repairs and batteries are not covered under this Contract but may be provided to children under the age of 21 as a Wrap Around Benefit. Simple articulation or academic difficulties that are not medical or surgical in origin are not covered under this Contract
- 3.1.20. **High colonics**
- 3.1.21. **Holistic or homeopathic care** including drugs and ecological or environmental medicine.
- 3.1.22. **Home delivery:** Services associated with non-emergent home delivery, unless prior authorized by the Contractor are excluded.
- 3.1.23. **Home Health Services:** Services provided specifically as benefits of the Home and Community Based Services Programs (HCBS), which include unskilled personal care, home modification, electronic monitoring, adult day services, alternative care facility services, homemaker services and respite care are not included under this Contract.
 - 3.1.23.1. Long Term Home as defined by 10 CCR 2505-10, Section 8.520.K.3.a is excluded.
 - 3.1.23.2. Home Health Services provided by a person who ordinarily resides in the Client's home or is an immediate family member are not covered.
- 3.1.24. **Hospice services.** Clients need not be disenrolled from their HMO to receive hospice services, but may continue to get care not related to the terminal illness from the HMO. Clients may request disenrollment.
- 3.1.25. **Hypnosis**
- 3.1.26. **Immunizations** related to foreign travel.
- 3.1.27. **Imaging (Radiology or X-ray) Services** performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.
- 3.1.28. **Infertility treatment,** including but not limited to embryo transplants, in vitro fertilization, and low tubal transfers, gamete interfallopian tube transfer and zygote interfallopian tube transfer.
- 3.1.29. **Inpatient** or residential rehabilitation for substance or alcohol abuse.

- 3.1.30. **Inpatient hospital** excluded services include:
 - 3.1.30.1. Psychiatric/psychological care included and covered through the Mental Health Capitation Program.
 - 3.1.30.2. Discharge medications and experimental drugs.
 - 3.1.30.3. Inpatient hospital services defined as experimental by the Medicare program.
 - 3.1.30.4. For Medicaid approved benefits, Medicare patients (having Medicaid as secondary coverage) will receive treatment in approved Medicare facilities when the Medicare benefit is limited to treatment in such facilities.
- 3.1.31. **Institutional care** when provided for the primary purpose of controlling or changing Client's environment, or if custodial care, domiciliary care, convalescent care (other than extended care) respite care, rest cures or hospice care.
- 3.1.32. **Isometric exercise**
- 3.1.33. **Expenses for medical reports**, including presentation and preparation.
- 3.1.34. **Laboratory services** performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.
- 3.1.35. **Long Term Home Health** as defined at 10 CCR 2505-10, Sections 8.520 is excluded.
- 3.1.36. **Mental Health** inpatient or outpatient psychiatric or psychological care that is a benefit of the Mental Health Capitation Program (MHCP). Hospital inpatient or outpatient care with a principal diagnosis listed in Exhibit F is a benefit of the Mental Health Capitation Program (MHCP). All other mental health services are a benefit of the MHCP if both the diagnosis and procedure codes are listed in Exhibit F.
- 3.1.37. **Newborn hospitalizations:** Continued stay of healthy newborns for any other reason after the mother's discharge is not a benefit under the medical assistance program.
- 3.1.38. **Paternity Testing.** Such services shall be reimbursed by the Medicaid Program and recouped through the court system.
- 3.1.39. **Personal comfort or convenience items.** Includes items such as hospital television, telephone, private room (except as Medically Necessary), modifications and alterations in homes, vehicles, or place of residence.
- 3.1.40. **Physical examinations** of the following nature are excluded:
 - 3.1.40.1. Examinations required by the county departments for the purpose of qualifying applicants for assistance or for the re-certification of recipients for assistance in the following categories: AND, AB, AFDC, or placement of children in Foster Care.
 - 3.1.40.2. Physical examinations for employment, licensing, marriage, insurance, school, camp, sports, or adoption purposes or requests by any institution, agency, or person other than the recipient's county department or the state department. Examination or treatment ordered by a court except when such treatment may be Medically Necessary and is provided by a network provider and/or authorized by the primary care physician.
- 3.1.41. **Private Duty Nursing (PDN).** Private duty nursing services are a Wrap Around Benefit.

- 3.1.42. **Psychiatric/psychological care** as follows:
 - 3.1.42.1. Milieu therapy
 - 3.1.42.2. Play therapy
 - 3.1.42.3. Day care
 - 3.1.42.4. Electroshock treatment rehabilitation
 - 3.1.42.5. Night care
 - 3.1.42.6. Family therapy
 - 3.1.42.7. Biofeedback
- 3.1.43. **Reversal** of surgically performed sterilization or subsequent re-sterilization.
- 3.1.44. Procedures, services and supplies relating to **sex change** or transformation.
- 3.1.45. **Skilled Nursing Facility Services** are a Wrap Around Benefit.
- 3.1.46. **Substance or alcohol abuse**, inpatient or residential rehabilitation.
- 3.1.47. **Surrogate Mother Services** or supplies received in connection with a Client acting as or utilizing the services of a surrogate mother.
- 3.1.48. **Transportation, non-emergent**, to medical appointments. This is a Medicaid benefit provided through the client's local county Department of Social Services, for the purpose of receiving covered medical services.
- 3.1.49. **Travel**, whether or not recommended or prescribed by a Physician or other medical practitioner.
- 3.1.50. **Vision correction procedures** for the purpose of vision correction that can be treated by corrective lenses, such as refractive keratoplasty, or radial and laser keratotomies.
- 3.1.51. **Wrap Around Benefits** are services that are Medicaid benefits not paid by the HMO. Wrap Around Benefits are paid for by the State of Colorado Medicaid program on a fee for service basis upon determination of Medical Necessity. Wrap-around services include, but may not be limited to the following:
 - 3.1.51.1. Auditory Services for children. HMO Covered Services include screening and Medically Necessary ear exams and audiological testing. Wrap Around Benefits include hearing aids, auditory training, audiological assessment and hearing evaluation.
 - 3.1.51.2. Comprehensive dental assessment, care and treatment for children.
 - 3.1.51.3. Dental services for adults are limited to emergency services and minimal Medically Necessary dental services for adults with concurrent medical conditions.
 - 3.1.51.4. Drug/Alcohol Treatment for pregnant women, to include assessment and treatment, is covered through the Special Connections Program administered by the Alcohol/Drug Abuse Division, Department of Human Services. Specified treatment centers only.

- 3.1.51.5. Extraordinary Home Health Services – Expanded EPSDT benefit which includes any combination of necessary home health services that exceed the maximum allowable per day; and services that must, for medical reasons, be provided at locations other than the child’s place of residence.
- 3.1.51.6. HCBS Services including case management (for Model 200 children); home modification, electronic monitoring, personal care and non-medical transportation.
- 3.1.51.7. Hospice services, however client may continue to get care not related to the terminal illness from the HMO, but will be disenrolled if requested.
- 3.1.51.8. Hospital back up level of care as set forth in 10 CCR 2505-10, Section 8.470.
- 3.1.51.9. Intestinal Transplants (excluding immunosuppressive medications, which are a covered HMO benefit) covered alone or with other simultaneous organ transplants (i.e., liver); coordinated by Department & HMO Case Manager; provided only at three out-of-state facilities: University of Pittsburgh, Jackson Memorial, and Mt. Sinai.
- 3.1.51.10. Non-emergency transportation to medical appointments for Covered Services only, through the client’s county of residence.
- 3.1.51.11. Private Duty Nursing (PDN), nursing services only.
- 3.1.51.12. Skilled Nursing Facility Services (skilled nursing and rehabilitation services) if client meets level of care certification. Wrap-around skilled nursing facility services include those services set forth at 10 CCR 2505-10, Section 8.440.1, notwithstanding the list of Covered Services set forth above. Wrap-around skilled nursing facility services also include any Medicare cross-over benefits.

Contract Routing Number: 14-68960

Exhibit C, Monthly Payment Rates

State of Colorado

Rocky Mountain 1281 Actuarial Certification

July 1, 2014 – June 30, 2015 Capitation Rate Ranges



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1. Background

This report provides documentation and actuarial certification for the Rocky Mountain Health Plan (RMHP) 1281 Program capitation rate range development for rates effective July 1, 2014 – June 30, 2015 (SFY15).

The 1281 Program is a pilot program beginning in SFY15. The pilot covers populations below 250 percent of the Federal Poverty Level (FPL) within Regional Care Collaborative Organization (RCCO) Region 1 counties: Mesa, Montrose, Garfield, Delta, Gunnison, Pitkin and Rio Blanco. RCCO Region 1 is one of 7 RCCO regions that are part of the Medicaid Accountable Care Collaborative (ACC) in the state of Colorado.

The Medicaid ACC, initiated in the spring of 2011, is a Medicaid program designed to improve the quality and cost effectiveness of health care in Colorado through the use of coordinated, client-centered systems. These ACC members receive the full Medicaid benefit package, and are assigned to a specific regulated region, called a RCCO. Rocky Mountain is RCCO 1 of the 7 medically-managed organizations within the state.

A global capitation payment rate range has been developed for the target populations within the RCCO 1 area. The aged, disabled, prenatal and adults with dependent children currently enrolled in the RMHP Prepaid Inpatient Health Plans (PIHP) are eligible for the 1281 program. The target population eligible members also include expansion adults who qualify on the basis of income, disability and full-benefit Medicaid-Medicare categories. The 1281 Initiative proposal, included in Appendix I, provides more background on the target populations and services covered under the pilot.

Rocky Mountain has proposed a 1281 payment reform pilot in response to the Colorado Department of HCPF request to the RCCO to create and implement a pilot program that establishes new payment methodologies in the Medicaid ACC Program. The proposed pilot includes reform initiatives that describe interventions designed to improve health outcomes, quality of care, as well as reduce cost for Medicaid patients. The proposal includes a global budget, global payment, and a reporting and gain sharing model. The model covers the full scope of covered physical health services and combines data from HCPF, the Statewide Data Analytics Contractor (SDAC) and RMHP for the entire population below 250 percent of the FPL no matter what type of coverage they have. The idea behind this approach is to achieve sustainability and create continuity of care as members move from one insurance type to another.

As a result of the initial proposal, HCPF requested that **Optumas** set a capitated rate for the proposed 1281 Program under Managed Care using a full-risk Global Payment model that includes risk corridor arrangements surrounding the Adults without Dependent Children (AwDC) expansion population. The initiative would be implemented beginning July 1, 2014. The program enrollment projections for SFY14 are anticipated to exceed 10,000 members.

As the consulting actuaries to The Colorado Department of Health Care Policy and Financing (HCPF), **Optumas** ensured that the methodology used to develop the SFY15 1281 program rate ranges complied with the Centers for Medicare & Medicaid Services (CMS) guidance, 42 CFR 438.6(c). In addition, the final capitation rates were developed using all of the applicable Actuarial Standards of Practice (ASOPs).

2. Rate Development Process

2.01 Overview

In developing the July 1, 2014 – June 30, 2015 rate range, **Optumas** developed a methodology that adheres to guidance provided by CMS in accordance with 42 CFR 438.6(c), the CMS standards for developing actuarially sound capitation rates for Medicaid managed care programs. CMS defines actuarially sound rates as meeting the following criteria:

1. They have been developed in accordance with generally accepted actuarial principles and practices,
2. They are appropriate for the populations to be covered and the services to be furnished under the contract, and
3. They have been certified by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows practice standards established by the Actuarial Standards Board.

In addition, **Optumas** ensured that all applicable Actuarial Standards of Practice were followed:

- ASOP 5 – Incurred Health and Disability Claim
- ASOP 23 – Data Quality
- ASOP 41 – Actuarial Communications
- ASOP 45 – The Use of Health Status Based Risk Adjustment Methodologies

Optumas applied this criteria in the development of the methodology for calculating capitation rate ranges for the July 1, 2014 – June 30, 2015 contract period. Appendix II(A) provides a brief summary of the CMS rate setting checklist with compliance to each section noted.

There were three sets of base data used to develop the July 1, 2014 – June 30, 2015 1281 Program rate ranges:

1. Rocky Mountain Administrative Services Organization (ASO) claims from FY11, FY12, and FY13 (July 1, 2010 through June 30, 2013), paid through January 31, 2014,
2. Rocky Mountain RCO claims from FY11, FY12, and FY13 (July 1, 2010 through June 30, 2013), paid through January 31, 2014,
3. Fee For Service (FFS) claims from FY11, FY12, and FY13 (July 1, 2010 through June 30, 2013), paid through January 31, 2014. Eligibility from the same time periods were also used to calculate member months.

The adjusted base data was developed using a blend of these three base data extracts, the State and **Optumas** worked in partnership to determine all adjustments needed to ensure that the adjusted base data was an appropriate proxy for the expected experience in the contract period. In order to translate the adjusted base data into capitation rates for the contract period, there were a series of adjustments applied, these are presented below in Figure 1.

Figure 1. Rate Development Process Adjustments

Adjustment	Overview
Base Data	Explanation of historical data used as the starting point for rate range development.
Base Data Adjustments	Adjustments to the base data including retrospective program changes.
Program Change Adjustments	Prospective program (population and benefit) changes not reflected in the adjusted base data.
Prospective Medical Trends	Accounts for the forecasted change in utilization and unit costs from the base to the contract period.
Managed Care Assumptions	Accounts for the change in delivery system from FFS to a managed care environment.
Expansion Population Development	Development of anticipated medical expenses for newly eligible expansion populations.
Non-Medical Loading	Administrative load to account for non-medical expenditures incurred by a MCO as well as a profit margin.
Rate Range Development	Assumptions used to develop actuarially sound rate ranges.

The remainder of this report provides further detail on each of the adjustment categories above.

2.02 Base Data

Data Reporting

The base data used for the 1281 Program rate range development is comprised of two years of data with incurred dates July 1, 2011 to June 30, 2013, paid through January 31, 2014. There were three different data extracts, representing the following populations:

- Rocky Mountain Administrative Services Organization (ASO) enrolled members
- Rocky Mountain Regional Care Collaborative Organization (RCCO) ACC enrolled members
- All other Medicaid Fee-for-Service (FFS) members

The data was limited to 1281 program specific criteria which includes eligible members residing in counties Delta, Garfield, Gunnison, Mesa, Montrose, Pitkin or Rio Blanco. The aged, disabled, prenatal and adults with dependent children currently in the RMHP Prepaid Inpatient Health Plans (PIHP) are eligible for the 1281 program.

Each of the four data extracts contained:

1. Inpatient claims
2. Outpatient claims
3. Professional claims
4. Pharmacy claims

In addition, enrollment data was provided by the Department of Health Care Policy and Financing (HCPF) that corresponded to the four data extracts.

To ensure compliance with ASOP 23 – Data Quality, **Optumas** conducted data validation analyses and benchmarked the data to previous base data used for rate setting purposes in other Colorado Medicaid programs for reasonableness.

The data validation analyses included:

1. Referential Integrity Checks – ensured that all claims included in base data were incurred by a member with a valid eligibility span that coincided with the incurred date associated with the specific claim.
2. Volume Checks – **Optumas** checked both volume of claims and total expenditures by category of service by looking at totals longitudinal. This ensured that any gaps or spikes in the data were identified and addressed before creating the base data.
3. Benchmarked Summarization – **Optumas** compared summarized data to other base data summaries used in other programs within Colorado, such as FFS data from the Denver Health Metro Area used in the HMO rate development.

Covered Services

The Rocky Mountain 1281 pilot program covers a range of medically necessary acute care services to the eligible members. The covered medical services is shown in Appendix II(B).

Covered Populations

The base data reflects ASO, RMHP, and FFS claims for 1281 Program target populations in Colorado which includes members residing in Delta, Garfield, Gunnison, Mesa, Montrose, Pitkin or Rio Blanco counties who are aged, disabled, prenatal or adults with dependent children that are currently in the RMHP Prepaid Inpatient Health Plans (PIHP). The data was divided into thirteen rate cells. The purpose of the rate cells is to group similar risk together in order to create credible and homogenous cohorts that assist in better matching payment to risk with regards to developing capitation rates. Actuarially sound rate ranges are developed for each of these rate cells. The thirteen rate cells are shown in Appendix II(C).

2.03 Base Data Adjustments

Once the base data, service categories and rating cohorts were developed, as discussed above, various adjustments were made in order to determine the adjusted base data that would be used for prospective rate development.

Source Development

Base data development, as well as the prospective rate range development, is created separately for four sources of data, ASO, RCCO, FFS and FFS Risk Adjusted. The ASO, RCCO, and FFS sources represent all experience from members who are in each respective program. The FFS Risk Adjusted source uses the FFS experience and applies a risk adjustment factor in order to project the FFS member experience on an ASO and RCCO acuity level. The risk adjustment factors used were developed using the Medicaid Rx risk assessment tool which uses National Drug Codes (NDCs) to assign members a risk score. The resulting factors used are shown in Appendix II(D) which represent the acuity difference from the FFS population to the ASO/RCCO populations.

Service Exclusions

In order to ensure that the rate ranges do not include any services that RMHP will not be responsible for under the capitation payment, **Optumas** has removed services stated as exclusions in the 1281 pilot contract. For the ASO members, **Optumas**, in working with HCPF and RMHP, determined that the current RMHP program inclusions are the same as those they will be responsible for in the 1281 pilot program. Because of this, any service not received as an ASO encounter has been removed from the ASO base data source as an excluded service. For the RCCO and FFS sources, **Optumas** worked with HCPF to identify service exclusions within the 1281 contract and has removed those services from the base data. The impacts of the service exclusions are shown in Appendix II(E).

Underreporting Adjustment

It was determined that the ASO data was underreported for the SFY12 and SFY13 time periods. Rocky Mountain provided supplemental data that was used to determine the distribution across service category for these dollars. A significant portion of the ASO underreported dollars was contained within the facility setting. The impacts of the underreporting are shown in Appendix II(F).

Pharmacy Reimbursement Adjustment

The MMIS data used for the ASO source was priced at Medicaid fee schedule levels. For the Pharmacy service category, it was agreed upon that RMHP would be reimbursed at Rocky Mountain reimbursement levels such that payment levels to RMHP would most appropriately align with payment levels made to providers. Utilizing data from RMHP that was priced at their reimbursement level, **Optumas** developed a downward adjustment to the Pharmacy service category to reflect the difference between Medicaid pricing and RMHP pricing. This adjustment resulted in an adjustment to the ASO source of -15.3% in SFY12 (-4.8% overall) and -15.3% in SFY13 (-4.0% overall).

COFRS Adjustment

In addition to the above adjustments, third party liability recoveries, unspecified adjustments and Colorado Financial Reporting System (COFRS) payments that are not attributed to individuals on a claim level have been applied as an adjustment to the SFY12 and SFY13 RCCO and FFS base data sources.

Unspecified Adjustments represent financial transaction dollars processed through the MMIS and placed into the appropriate service category. The financial transactions that are provider specific, but not client specific, are included as an “unspecified adjustment”. Those financial transactions impact the dollar amount of the RCCO and FFS claims at an aggregated level. The examples are included, but not limited to, all audits that resulted in the cost settlements by providers; any law suit settlement for a provider.

COFRS payments are any cost/claim settlements handled outside of the MMIS, for example lawsuit settlements. Since these are related to settlements for Medicaid members, they decrease the overall cost of the Medicaid program. An adjustment has been developed and applied to the fully incurred medical expenses, by category of service, to account for the RCCO and FFS portion of total COFRS claims.

As this is downward adjustments to the cost per member, we have accordingly adjusted the RCCO and FFS base data to reflect the lower cost. The impacts of the COFRS and unspecified adjustment are shown in Appendix II(G).

IBNR Adjustment

Estimates for the incurred but not yet reported (IBNR) expenditures were developed for each source of the data provided. As previously mentioned, the base data used to develop the 1281 rate ranges were SFY12 and SFY13 data paid through January 31, 2014. Because there was upwards of 7 months of run-out on the data, no IBNR adjustment was applied to the SFY12 time period and a minimal adjustment was applied to the SFY13 time period. The SFY13 IBNR factors are shown in Appendix II(G).

Retrospective Program Changes & Trend

In order to make both years on a SFY13 basis, programmatic changes and trend were applied to the SFY12 base data.

Retrospective program change adjustments recognize the impact of eligibility or benefit changes occurring during the base period. The following list summarizes all applicable retrospective program changes:

- A Pharmacy reduction of -0.7% resulting from the State maximum Allowable Cost expansion was applied in SFY13 was applied to SFY12. Note, this adjustment was not applied to the ASO source data as a separate Pharmacy adjustment was applied for the ASO source to reflect RMHP reimbursement.
- A home health increase of 4.5% resulting from provider rate increases in FY13 was applied to SFY12. Once again, this adjustment was not applied to the ASO source data as a separate the underreporting adjustment referenced above is considered to account for this impact.

Utilization and Unit Cost trends were applied to the SFY12 data to bring it to a SFY13 basis. The trends used were applied by service category and were based on historical data as well as **Optumas'** experience in other States. An overall impact of approximately 4.5% was applied to each source. Specific historical trend factors are shown in Appendix II(H).

Data Year Blends

After applying the adjustments listed above, both years of base data were considered to be on a SFY13 basis. The two years were then blended together to form the final SFY13 adjusted base data for each of the four data sources. The weights given to each year are shown in Appendix II(I).

Data Source Blends

In conjunction with the year blend, the adjusted base data was developed using a blend of the ASO, RCCO, and FFS data extracts, along with the FFS Risk Adjusted experience. This source blend was developed as a proxy for the expected experience in the contract period. FFS Risk Adjusted experience was used for rate cells that had lower credibility due to membership levels in ASO. The weights given to each source of data by category of aid are shown in Appendix II(J).

2.04 Prospective Program Changes Adjustments

Prospective program change adjustments recognize the impact of eligibility or benefit changes occurring after the base period. The following list summarizes all applicable prospective program changes:

- The following categories of service have been affected by a 2.0% proposed budget increase as of July 2013: DME, Emergency Room, Emergency Transportation, EPSDT, FQHC & Rural Health, Inpatient Hospital, Lab and X-Ray, Outpatient Hospital, and

Physician Services. Additionally, Home Health will be affected by an 8.2% proposed budget increase as of July 2013. These increases resulted in an upward adjustment to the blended SFY13 base data.

- Beginning in February of 2013, Colorado moved to the Average Acquisition Cost (AAC) method for pharmacy reimbursement. An additional downward adjustment was made to reflect projected savings through the SFY15 contract period. This program change was applied to RCCO and FFS data sources only. The ASO data is adjusted to be priced at Rocky Mountain reimbursement levels and, therefore, this program change is not applicable.
- The Department proposed an increase to general funding, as of July 2014, to ensure that reimbursements are sufficient in order to maintain provider participation and client access to health care. The request will result in an upward adjustments of 2.0% to the following categories of service: DME, Emergency Room, Emergency Transportation, FQHC & Rural Health, Inpatient Hospital, Lab and X-Ray, Outpatient Hospital, Dialysis, Physician, Specialist and Home Health Services.

The impacts of program changes by time period and service category are shown in Appendix II(K).

2.05 Prospective Medical Trends

Trend factors were applied to estimate the change in utilization rate (frequency of services) and unit cost (pure price change, technology, acuity/intensity, and mix of services) of services over time. These trend factors were used to project the costs from the base period to the future contract period. Trends were developed on an annualized basis and applied by major service category from the midpoint of the SFY13 base period to the midpoint of the SFY15 contract period. Prospective trends are listed in Appendix II(L).

2.06 Managed Care Assumptions

The managed care assumptions assume efficiencies in utilization and cost due to changing from a FFS delivery model to managed care, with specific assumptions for each category of service and rating cohort. **Optumas** leveraged experience in other Medicaid programs in addition to an independent consulting physician with 30+ years of experience in Medicaid Managed Care to assist in determining initial and final assumptions. The assumptions imply the improvement of patient care and achievement of overall cost savings resulting from the implementation of the 1281 Program.

The managed care assumptions are not always a downward adjustment. Utilization reductions in some services may result in an increase in utilization for other services. For example, under managed care, more PCP visits will occur which will result in less unnecessary specialist visits and likely more prescriptions. However, the additional prescriptions will be offset through better overall pharmaceutical management.

The lower managed care savings assumption reflects the assumption that this population will have utilization patterns in the first year consistent with an underserved population. Typically, underserved

populations have increases in utilization in certain services due to increased access balanced by decreases in utilization due to better care coordination. Thus, our managed care assumptions reflect a “net” adjustment – we assume both increases and decreases in utilization due to increased access and increased care management. This net adjustment approach has been borne out by experience in expansion programs in Maine, Massachusetts, Connecticut, Ohio, Kansas, New Mexico, and California over the last 5 years. While we expect the MCO to have an impact on the utilization and reflected this is our net adjustment, in our experience, the bulk of this impact will materialize in the second year of program.

The final managed care assumptions that were used and applied to the Medicaid data are listed in Appendix II(M).

2.07 Expansion Populations

With the implementation of the Affordable Care Act (ACA), beginning January 1, 2014 new populations will be eligible for Medicaid and the RMHP 1281 program. Prior to the Affordable Care Act Expansion, the AFDC Male and Female cohorts offered coverage to individuals within 61%-100% FPL range. The Expansion now offers coverage to 61%-133% FPL, and calls these newly eligibles the Expansion Parents. Additionally, some childless adults up to 10% FPL are covered by Medicaid. Separate rate cells and capitation rates were determined for these populations in addition to the rating cohorts referenced above.

Expansion Parents Medical Expense Development

The expansion parent population is broken out into the following categories of aid:

- Expansion Parent M (61%-133% FPL)
- Expansion Parent F (61%-133% FPL)

For the expansion parents both currently enrolled and newly eligible for Medicaid, ASO, RCCO and FFS risk adjusted data spanning from SFY12 to SFY13 was used to develop the base data. After accounting for base data adjustments, programmatic changes, trend and managed care assumptions, the AFDC/CWP Adults 19+ M rating cohort was used as a starting point for the Expansion Parent M rate development and the AFDC/CWP Adults 19+ F rating cohort was used as a starting point for the Expansion Parent F rate development.

The expansion parent populations 61%-133% FPL are a newly eligible group as of January 1, 2014. Because of this, there is an anticipated pent-up demand impact on this population who are expected to have additional utilization due to the previous lack of healthcare coverage. As the starting basis for the pent-up demand adjustment, **Optumas** used experience from the New Mexico State Coverage Insurance (SCI) population, which is a Medicaid waiver funded program that offers low cost health insurance through employer-based benefits. The analysis was a longitudinal study in which member costs were analyzed for the first 6-12 months of enrollment compared to how the costs looked after the first year. The study then compared the costs by major category of service across those time periods. Two downward adjustments to these factors are then applied. First is a 0.75 factor to account for ‘fading

away' impacts of pent-up demand since the transitioning members will have already been eligible for Medicaid for half of a year prior to the FY15 RMHP 1281 program contact period. Second is a 0.50 factor to account for the portion of the population who are already covered by Medicaid within the AFDC male and female cohorts (adults 61%-100%). The final pent-up demand factors for the expansion parent populations are listed in Appendix II(N).

These new members are additionally expected to have a lower risk due to the higher income levels than those used for the starting basis for rate development. Multiple approaches were used to develop this acuity adjustment. As mentioned above, a portion of the expansion parent members are already covered by Medicaid within the AFDC male and female cohorts from 61%-100% FPL. Comparisons of PMPM expenditures using historical data for the AFDC male and female cohorts for FPLs 0%-60% were compared to those with FPLs 61%-100% FPL. Additionally, these two populations acuity were compared utilizing the Medicaid Rx risk score tool. For the Expansion Parent female cohort, both methods produced significantly similar results that suggest the higher FPL population acuity is between less than that of the lower FPL population acuity. For the Expansion Parent male cohort, results suggested similar acuity between the two populations. The final acuity factor used for the Expansion Parents female population was 91.6% and the final acuity factor used for the Expansion Parent male population was 100.0%.

New expansion populations will receive certain additional ABP rehabilitative services. As HCPF currently covers rehabilitative services, **Optumas** developed additional utilization assumptions that would result from the added Habilitative service coverage. The resulting impact is a 0.1%-0.2% increase to the expansion parent populations medical spend.

Expansion Childless Adults Medical Expense Development

The childless expansion population is currently covered in Medicaid FFS up to 10% FPL, and is now transitioning to cover members up to 133% FPL. Medical data was available for the 0-10% FPL AwDC cohort. While available CRG weights were compared for reasonableness, **Optumas** ultimately used data available for currently covered AFDC and disabled adults, in conjunction with self-reported Current Population Survey (CPS) data from the Bureau of Labor Statistics.

The CPS data has the following three classifications: Severe Work Disability, Non-Severe Work Disability, and No Work Disability. We assume that the first two classifications are more representative of a Disabled population while the third classification is more representative of a Non-Disabled population. In addition to the data observed from CPS, **Optumas** assumed take-up factors, to account for the level of risk that will enroll due to current health care needs. The combination of original CPS blend along with the take-up factors and emerging population data specific to Colorado resulted in a blend of 46% non-disabled female, 40% non-disabled male and 14% disabled.

This yields a 14% disabled rate with roughly a 2.8 relativity for the lower bound Medical PMPM (disabled PMPM of \$1,059.26 and blended AFDC PMPM of \$372.38). The resulting acuity adjustment is $\$441.99/\372.38 or 19%.

In addition to the adjusted acuity of the AwDC population, there is an anticipated pent-up demand impact on this population who are expected to have additional utilization due to the current lack of

healthcare coverage. As the starting basis for the pent-up demand adjustment, **Optumas** used experience from the New Mexico SCI population. The analysis was a longitudinal study in which member costs were analyzed for the first 6-12 months of enrollment compared to how the costs looked after the first year. The study then compared the costs by major category of service across those time periods. Two downward adjustments to these factors are then applied. First, a 0.75 factor is applied to account for 'fading away' impacts of pent-up demand since the transitioning members will have already been eligible for Medicaid for half of a year prior to the FY15 RMHP 1281 program contact period. Second, a 0.93 factor is applied to account for the portion of the population who are already covered by Medicaid within the AwDC cohort (Adults 0%-10%). The final pent-up demand factors for the AwDC population are listed in Appendix II(N).

Since the expansion adult rates have been developed using data that is already adjusted for a managed care environment, no new assumptions are required.

2.08 Expansion Services

In addition to the newly eligible adults, beginning January 1, 2014 Colorado has implemented the Alternative Benefit Plan for its Medicaid members. While most of the additional benefits are covered FFS and out of the scope of the 1281 pilot, the following additional benefits will be new for 1281 members:

- Expanded Preventive services – This applies to all rating cohorts, including Expansion Parent Female, Expansion Parent Male and AwDC rating cohorts.
- Habilitative services – This applies only to the Expansion Parent Female, Expansion Parent Male and AwDC rating cohorts, as described above.

In order to develop a rate range for the expanded Preventive services, **Optumas** reviewed the new services being offered with its internal clinician, to develop research and clinical based utilization estimates. As HCPF currently covers rehabilitative services, **Optumas** developed additional utilization assumptions that would result due to the added Habilitative service coverage. The resulting additive PMPM rate ranges for the Preventive and Habilitative services are listed in Appendix II(O) and II(P).

2.09 AwDC Risk Corridor

As a result of the unknown risk level associated with the emerging AwDC population, the State has developed a risk corridor as a risk-mitigation strategy. To the extent that the selected rate is overstated or understated by certain barrier points, dollars would be paid to the MCO from the State or paid back to the State from the MCO respectively. The details of the risk corridor are included in Appendix II(Q).

2.10 Inclusion of Non-Medical Loading

Administrative and Profit Loading

The non-medical load measures the dollars associated with components such as administration, profit, risk, and contingencies and are expressed as a percentage of the capitation rate. **Optumas** utilized their experience with non-medical expenses in other states, on both a PMPM and percentage basis. The resulting administrative and profit ranges are listed in Appendix II(R).

Affordable Care Act Health Tax

Based on recent calls hosted by CMS, the Health Insurer Fee should not be applied to any populations that were not covered under managed care in the previous year on which the tax is based (such as expansion populations for CY14). The population that is covered by the 1281 demonstration was not covered under managed care in SFY13. Therefore, **Optumas** did not include the Health Insurer Fee for the 1281 program in SFY15. **Optumas** is working with HCPF and CMS to develop a methodology that will address the Health Insurer Fee that will be assessed in SFY16 based on SFY15 revenues.

2.11 Development of Rate Ranges

In developing the capitation rates by rate cell, **Optumas** relied on multiple actuarial assumptions. These assumptions were estimates of the impacts of various components of the rate development methodology. Multiple sources of program-specific information, industry information and in-house proprietary actuarial tools were relied upon to ensure that these assumptions were well-informed, unbiased, and as accurate as possible. Per the CMS rate checklist, **Optumas'** approach to developing actuarially sound rate ranges required a review of all of the assumptions and adjustments used in the rate development process in order to determine PMPM costs at specific points in the rate ranges, including the lower and upper bounds.

The upper and lower bounds of the rate range are intended to represent amounts at which an appropriately managed MCO would be able to meet the access to care and quality of care standards as described in their contract. **Optumas** examined variations in each component of the rate development process to determine these specific points in the range. These variations, examined in isolation as well as in combination, resulted in a series of capitation rates that, when combined, defined the rate ranges.

To develop the rate ranges, we varied the trend (+/-0.5%), managed care savings (+/-1.0%) and administration (+/-1.0%). In addition, to account for the variance inherent in the base data we developed a claims fluctuation component of the rate range using the 90th confidence interval. The variations were developed using the ASO and RCCO base data.

Each assumption was not developed in isolation, but instead were developed to reflect the interaction between actuarial assumptions. For example, if we assumed a lower trend and managed care savings on the lower bound, then we coupled that assumption with a higher administrative assumption knowing

that more medical management efforts would be needed to achieve the lower trend and managed care savings.

The payment rates and rate ranges are shown in Appendix III.

3. Actuarial Certification

I, Zachary Aters, Senior Actuary at **Optumas** and Member of the American Academy of Actuaries (MAAA), am certifying the calculation of the rate ranges shown in Appendix III. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time to time by the Actuarial Standards Board.

The capitation rates provided with this certification are considered actuarially sound for purposes of the 42 CFR 438.6(c), according to the following criteria:

- The capitation rate ranges have been developed in accordance with generally accepted actuarial principles and practices;
- The capitation rate ranges are appropriate for the populations to be covered, and the services to be furnished under the contract; and
- The capitation rate ranges meet the requirements of 42 CFR 438.6(c).

Appendix II(A) contains a crosswalk between the CMS rate setting checklist and this certification letter.

The actuarially sound rate ranges that are associated with this certification are effective July 1, 2014 through June 30, 2015 for Colorado's 1281 Pilot Program.

The actuarially sound capitation rate ranges are based on a projection of future events. Actual experience will vary from the experience assumed in any rate picked within the rate ranges. The capitation rates offered may not be appropriate for any specific MCO. An individual MCO should review the rates in relation to the benefits that it is obligated to provide to the covered population. The MCO should evaluate the rates in the context of its own experience, expenses, capital, surplus, and profit requirements prior to agreeing to contract with the State. The MCO may require rates above, within, or below the actuarially sound rate range associated with this certification.

Should you have questions on any of the above, please feel free to contact me at 480.588.2495 for any additional information.

Sincerely,



Zachary Aters, ASA, MAAA
Senior Actuary

4. Appendices

Appendix I. Rocky Mountain 128 Initial Proposal Language



Executive Summary

On behalf of our community partners in western Colorado, and throughout the Accountable Care Collaborative, Rocky Mountain Health Plans (RMHP) is pleased to submit the enclosed proposal for a payment reform pilot, pursuant to HB 12-1281 (C.R.S. § 25-5.5-415). We have created a Global Budget, Global Payment, reporting and gainsharing model that 1) encompasses the full scope of covered *physical health, behavioral health and substance use disorder services*; and, 2) aggregates data shared by the Department, the SDAC, the BHO and Rocky Mountain Health Plans – across the entire population below 250 percent of the Federal Poverty Level – without regard to coverage type. This structure will enable the Sponsors to achieve sustainability and create continuity of care as clients transition between Medicaid and private, subsidized coverage (a.k.a. "churn"). The Pilot will operate in seven RCCO 1 counties: Mesa, Montrose, Delta, Gunnison, Pitkin, Garfield and Rio Blanco.

Budget Neutrality and Savings

Our proposal is unequivocally budget neutral and will create savings for the Department in both Year 1 and Year 2 of the proposed Pilot. Beyond minimum savings attributable to the administrative simplification proposed by RMHP, there is significant additional savings potential for the Department associated with the Sponsors' interventions, logic model, Global Payment and gainsharing model.

The Sponsors' ability to produce budget neutrality and savings for the Department (as well as sustainability for themselves) is grounded upon: 1) An approach to patient activation, behavior change and self-management that reflects a large body of experience and evidence; 2) A logical re-alignment of enrollment, contracts, and payments, as follows:

	Pilot Year 1 (2014)	Pilot Year 2 (2015)	Combined Savings
Minimum Department Savings	\$1,714,546	\$3,135,668	\$4,850,214
Potential Additional Department Savings for Target Population (Gainsharing)	\$ 361,302	\$ 590,714	\$ 952,013
Potential Additional Department Savings in PCCM ("RCCO 1.0")	\$2,140,782	\$1,694,779	\$3,835,561
Total Potential Department Savings	\$4,216,630	\$5,421,161	\$9,637,791

Executive Committee

Principal RCCO partners in this effort include two community mental health centers - Colorado West Regional Mental Health Center and Midwestern Colorado Mental Health Center, both of which have been collaborating actively within the Region 1 RCCO since its inception, with support from Colorado Health Partnerships, the BHO. These partners have formed an Executive Committee to provide leadership and oversight for the project, which will also include the following members: a consumer, a Federally-Qualified Health Center (FQHC), a privately-practicing PCMP, a local public health department (LPHA), a hospital and a behavioral health

Executive Summary
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integration expert with the University of Colorado Department of Family Medicine (hereinafter referred to as "The Sponsors").

Enrollment and Payment

Target Population – The Target Population includes expansion adults who qualify on the basis of income, disability and full-benefit Medicaid-Medicare categories ("RCCO 2.0"). The Target Population accounts for 16% of the total enrollment in RMHP's existing PIHP agreement.

Broader Population – All other categories will be transitioned into the existing RCCO PCCM structure ("RCCO 1.0"). These categories currently account for 84% of the total population currently enrolled in RMHP's PIHP agreement. The Sponsors' planned interventions will encompass both the Target and the broader population, even though Global Payments will be made only for the Target Population. Consolidation of the PIHP population within the RCCO also assures compliance with the UPL requirement.

Global Payment, Gainsharing and Value - The RCCO will receive full-risk Global Payments from the Department for the Target Population. The Department will spend no more than 100% of FFS for Covered Services, and make lower administrative payments than it does under current contracts. BHO payment and contractual arrangements with the Department will remain unchanged. If actual costs for Covered Services in the Global Budget are lower than payments, 30% of the difference will be returned to the Department. The Sponsors will retain remaining gains - if and only if specific quality metrics are achieved. If costs are reduced but minimum quality targets are not achieved, 100% of the difference between projected and actual costs for Covered Services will be returned to the Department.

Primary Care - PCMPs will receive significantly enhanced PMPM payments, on a risk-adjusted basis, at a baseline equivalent to 125% of Medicaid FFS payments. Payments will be higher for patients with more complex needs to ensure that "cherry picking" does not occur. An additional 5% will be paid, contingent upon meeting quality targets (independently of cost). Further, 30% of any gains between Global Payments to the RCCO and actual costs for Covered Services will be paid to PCMPs. A 5% cost-accountability recoupment will be applied by the RCCO if actual costs exceed targets in the Global Budget for attributed patients. Enhancements above 100% of FFS will be made by RMHP, not financed by the Department through Global Payment.

Community Mental Health - CMHCs will receive direct payments via the RCCO for workforce development, as well as payments from PCMPs (financed by the RCCO, but controlled by the PCMPs) for integrated behavioral health services. Additionally, CMHCs will receive 30% of any gains, as outlined above, and will carry risk for failure to achieve performance targets that is proportionate to their total share of the Global Budget.

Specialty Care - In order to ensure appropriate access and coordination, RMHP will make enhanced payments to specialists (equivalent to Medicaid + 30%) through a mix of fee and non-encounter payments for communication and co-management with PCMPs.



Description of Organization

Rocky Mountain Health Plans (RMHP) is honored to serve as the contracting Regional Care Collaborative Organization for Region 1 of the Accountable Care Collaborative (ACC). We fully support the Department's efforts to undertake an innovative approach to Medicaid reform. More importantly, we understand that sustainable reform is possible only through the creation of a collaborative structure, which promotes local leadership and data-driven accountability. RMHP supports the ACC because we know from experience that flexible partnerships among multiple public and private organizations operating with direct accountability to each other, as well as the communities they serve, is necessary to achieve the Triple Aim: better care and better health at lower costs.

Over the past three years, RMHP and several committed leaders have worked to promote a shared vision of *Community Integration*, in which we collectively invest in the development of new skills, tools and operating arrangements that are fundamental to the creation of value for both large purchasers and individual consumers alike. Our core principle in this work is simple: *walk the talk*. By investing in each other, holding ourselves to high standards, learning from our experiences and from others who share our vision, we have been able to create a tremendously valuable community infrastructure, which is essential to the successful execution of the enclosed proposal. This proposal includes:

- Broad-based practice transformation, collaborative learning and measurement: RMHP and its partners have been honored to receive national recognition for our role as a [Beacon Community](#) sponsor operating under a Cooperative Agreement with U.S. HHS/ONC. Further, in addition to being deemed an *Aligned Payer* within the [Comprehensive Primary Care initiative](#), we are contracted to serve as a technical assistance provider on behalf of the CMS Innovation Center for western Colorado primary care practices – most of which are now also contracted as PCMPs within the ACC.
- Advanced technology, data aggregation and use at the point of care: RMHP and local physician groups, hospitals and community agencies have invested in and continue to expand data sharing relationships with Quality Health Network. QHNs infrastructure is producing very powerful results for PCMPs and the RCCO alike, as recently recognized by *Healthcare Informatics* with a [2013 Innovators Award](#) for our work to make advanced patient engagement and risk stratification tools available to Medicaid PCMPs – at the point of care in regular clinical workflows.
- Payment for behavioral health integration: RMHP is investing heavily in behavioral health integration, and actively working to promote seamless care for both the body and mind. We recognize that evidence-based supports for *behavior change, patient activation and self-management* must be available to all individuals – not just people – as well as those with mental health diagnoses. As such, we are participating in the [SHAPE \(Sustaining Health Care across Integrated Primary Care Efforts\)](#) payment reform evaluation, in partnership with the Colorado Health Foundation, the Collaborative Family Health Care Association, and the University of Colorado Department of Family Medicine.

None of these efforts, however, will be sustainable without robust payment reform. To that end, we have created a diverse, but focused, Executive Committee to oversee implementation of our proposed pilot (as described in detail within the enclosed executive summary, and Attachment I – Business Structure). The Committee will provide monthly monitoring of the proposed Global Budget, and quarterly reports to the Department, with the expectation that our progress will be monitored closely and shared publicly with other stakeholders to accelerate learning throughout the Colorado ACC.

Appendix II. Rate Development Components

Appendix II(A) CMS Checklist

CMS Item#	Subject	Compliance	FY15 Colorado 1281 Program Rate Comments
AA.1.0	Overview of rate-setting methodology	✓	See Section 2.01.
AA.1.1	Actuarial Certification	✓	See Section 3.
AA.1.2	Projection of expenditures	✓	N/A
AA.1.3	Procurement, prior approval, and rate-setting	✓	State set rates are developed.
AA.1.4	N/A	✓	There is no item AA.1.4 in the CMS Checklist.
AA.1.5	Risk contracts	✓	N/A
AA.1.6	Limit on payment to other providers	✓	N/A
AA.1.7	Rate modifications	✓	The rates certified in this report have an assumed effective date of July 1, 2014 to June 30, 2015. If the effective date changes, these rates are subject to change.
AA.2.0	Base year utilization and cost data	✓	See Section 2.02.
AA.2.1	Medicaid eligibles under the contract	✓	Only program eligibles and cost data have been included in the rate base.
AA.2.2	Dual eligibles	✓	Dual eligible members are their own rating cell within the rate range development.
AA.2.3	Spend down	✓	Spend down eligibles are not part of the program.
AA.2.4	State Plan services only	✓	Only State Plan Services were included in the base data.
AA.2.5	Services that may be covered by a capitated entity out of contract savings	✓	N/A
AA.3.0	Adjustments to base year data	✓	See Section 2.03.
AA.3.1	Benefit differences	✓	See Section 2.04.
AA.3.2	Administrative cost allowance calculations	✓	See Section 2.10.
AA.3.3	Special population adjustments	✓	As discussed in section 2.07 of this report, the rates were adjusted to reflect new Expansion populations
AA.3.4	Eligibility adjustments	✓	N/A
AA.3.5	DSH payments	✓	The 1281 Program rates do not include DSH payments.

CMS Item#	Subject	Compliance	FY15 Colorado 1281 Program Rate Comments
AA.3.6	Third party liability (TPL)	✓	RMHP is responsible for collection of any TPL recoveries so the data used to create the base rates accordingly do not include these amounts.
AA.3.7	Copayments, coinsurance, and deductibles in capitated rates	✓	Rate ranges are developed net of copayments, coinsurance, and deductibles.
AA.3.8	Graduate medical education (GME)	✓	The 1281 Program rates do not include GME payments.
AA.3.9	FQHC and RHC reimbursement	✓	The capitation rate uses the rate under the alternative payment methodology approach. Reconciliations will be conducted to reflect changes in the FQHC encounter rate applicable during the term of the contract, as well as reported utilization.
AA.3.10	Medical cost trend inflation	✓	See Section 2.05.
AA.3.11	Utilization adjustments	✓	See Section 2.05.
AA.3.12	Utilization and cost assumptions	✓	The population in the base data is comparable to the population that will be covered from July 1, 2014 – June 30, 2015.
AA.3.13	Post-eligibility treatment of income (PETI)	✓	N/A
AA.3.14	Incomplete data adjustment	✓	See Section 2.03.
AA.4.0	Establish rate category groupings	✓	See Section 2.02.
AA.4.1	Age	✓	See Section 2.02.
AA.4.2	Gender	✓	See Section 2.02.
AA.4.3	Locality / Region	✓	See Section 2.02.
AA.4.4	Eligibility categories	✓	See Section 2.02.
AA.5.0	Data Smoothing	✓	Data smoothing was guided by the reasonableness checks conducted on the data and described on Rate Certification Letter Section 3.
AA.5.1	Special populations and assessment of the data for distortions	✓	Outlier experience was reviewed and population-level distortion was addressed where necessary.
AA.5.2	Cost-neutral data smoothing adjustment	✓	No cost-neutral data smoothing adjustment was deemed necessary.

CMS Item#	Subject	Compliance	FY15 Colorado 1281 Program Rate Comments
AA.5.3	Risk Adjustment	✓	FFS data was risk adjusted to approximate ASO/RCCO experience as referenced in Section 2.03.
AA.6.0	Stop loss, reinsurance, or risk sharing arrangements	✓	The Expansion AwDC population will have a risk corridor program as referenced in Section 2.09.
AA.6.1	Commercial reinsurance	✓	N/A
AA.6.2	Simple stop loss program	✓	N/A
AA.6.3	Risk corridor program	✓	The Expansion AwDC population will have a risk corridor program as referenced in Section 2.09.
AA.7.0	Incentive arrangements	✓	N/A

Appendix II(B) Covered Medical Services

Covered Services
Inpatient Hospital
Emergency Room
Home Health
FQHC & Rural Health Clinic
Outpatient Hospital
Laboratory & X-Ray
Physician - ER
Physician - IP
Physician - Office
Specialist
Emergency Transportation
Other
Pharmacy

Appendix II(C) Rate Cells

Population
AFDC/CWP Adults 19+ M
AFDC/CWP Adults 19+ F
BC Women
AND/AB - SSI Non-Dual <45
AND/AB - SSI Non-Dual 45+
OAP A – Non-Dual
OAP B - SSI Non-Dual
BUYIN Working Adult Disabled
DUAL
DUAL - Medicaid Full/Medicare Partial
Expansion Parent Male
Expansion Parent Female
AwDC

Appendix II(D) FFS Risk Adjusted Acuity Factors – ASO/RCCO → FFS

Population	SFY12	SFY13
AFDC/CWP Adults 19+ M	42%	28%
AFDC/CWP Adults 19+ F	32%	25%
BC Women	30%	23%
AND/AB - SSI Non-Dual <45	28%	20%
AND/AB - SSI Non-Dual 45+	40%	23%
OAP A – Non-Dual	35%	20%
OAP B - SSI Non-Dual	39%	29%
BUYIN Working Adult Disabled	N/A	N/A
DUAL	N/A	N/A
DUAL - Medicaid Full/Medicare Partial	N/A	N/A

Appendix II(E) Service Exclusion Impacts

Source	SFY12	SFY13
ASO	-1.7%	-2.6%
RCCO	-1.8%	-3.4%
FFS	-8.7%	-9.7%

Appendix II(F) Underreporting Factors

Covered Services	SFY12 ASO Underreporting Adjustment	SFY13 ASO Underreporting Adjustment
Inpatient Hospital	0.0%	2.9%
Emergency Room	1.6%	30.3%
Home Health	0.3%	6.1%
FQHC & Rural Health Clinic	0.0%	0.0%
Outpatient Hospital	0.8%	23.3%
Laboratory & X-Ray	0.0%	0.1%
Physician – ER	0.0%	0.6%
Physician – IP	0.0%	3.1%
Physician - Office	0.0%	3.0%
Specialist	0.0%	2.8%
Emergency Transportation	0.0%	0.0%
Other	0.5%	18.7%
Pharmacy	0.0%	0.0%
Total	0.3%	8.9%

Appendix II(G) COFRS Adjustment

Covered Services	SFY12 FFS/RCCO COFRS Adjustment	SFY13 FFS/RCCO COFRS Adjustment
Inpatient Hospital	-0.1%	-0.1%
Emergency Room	0.0%	0.0%
Home Health	-0.6%	0.0%
FQHC & Rural Health Clinic	0.0%	0.0%
Outpatient Hospital	-0.4%	-0.5%
Laboratory & X-Ray	-0.1%	0.0%
Physician - ER	-0.1%	-0.1%
Physician - IP	-0.1%	-0.2%
Physician - Office	0.0%	-0.1%
Specialist	0.0%	0.0%
Emergency Transportation	-0.2%	0.0%
Other	0.0%	0.0%
Pharmacy	0.0%	-0.1%
Total	-0.1%	-0.1%

Appendix II(H) Historical Trend Assumptions

COS	Source Blend Trend
Inpatient Hospital	5.5%
Emergency Room	3.5%
Home Health	2.5%
FQHC & Rural Health Clinic	3.5%
Outpatient Hospital	4.5%
Laboratory & X-Ray	7.5%
Physician - ER	3.5%
Physician - IP	5.5%
Physician - Office	3.5%
Specialist	3.5%
Emergency Transportation	4.5%
Other	3.5%
Pharmacy	4.5%
TOTAL	4.5%

Appendix II(I) Base Data Year Blend

Source	SFY12	SFY13
ASO	30.0%	70.0%
RCCO	0.0%	100.0%
FFS	30.0%	70.0%
FFS Risk Adjusted	30.0%	70.0%

Appendix II(J) Base Data Source Blend

Source	ASO	RCCO	FFS	FFS Risk Adjusted
AFDC/CWP Adults 19-44 M	85.0%	10.0%	0.0%	5.0%
AFDC/CWP Adults 45+ M	85.0%	0.0%	0.0%	15.0%
AFDC/CWP Adults 19-44 F	90.0%	10.0%	0.0%	0.0%
AFDC/CWP Adults 45+ F	85.0%	0.0%	0.0%	15.0%
BC Women	100.0%	0.0%	0.0%	0.0%
AND/AB - SSI Non-Dual <45	90.0%	10.0%	0.0%	0.0%
AND/AB - SSI Non-Dual 45+	90.0%	10.0%	0.0%	0.0%
OAP A – Non-Dual	60.0%	0.0%	0.0%	40.0%
OAP B - SSI Non-Dual	60.0%	0.0%	0.0%	40.0%
BUYIN Working Adult Disabled	85.0%	15.0%	0.0%	0.0%
DUAL	100.0%	0.0%	0.0%	0.0%
DUAL - Medicaid Full/Medicare Partial	100.0%	0.0%	0.0%	0.0%

Appendix II(K) Program Change Adjustments

COA	SFY14	SFY15
Inpatient Hospital	2.0%	2.0%
Emergency Room	2.0%	2.0%
Home Health	8.2%	2.0%
FQHC & Rural Health Clinic	2.0%	2.0%
Outpatient Hospital	2.0%	2.0%
Laboratory & X-Ray	2.0%	2.0%
Physician - ER	2.0%	2.0%
Physician - IP	2.0%	2.0%
Physician - Office	2.0%	2.0%
Specialist	2.0%	2.0%
Emergency Transportation	2.0%	2.0%
Other	2.0%	2.0%
Pharmacy	-0.1%	0.0%
TOTAL	1.4%	1.4%

Appendix II(L) Prospective Trend Assumptions

COS	Source Blend	
	LB	UB
Inpatient Hospital	0.2%	1.8%
Emergency Room	1.5%	3.0%
Home Health	1.0%	2.5%
FQHC & Rural Health Clinic	2.3%	3.8%
Outpatient Hospital	0.5%	2.0%
Laboratory & X-Ray	1.5%	3.0%
Physician - ER	1.0%	2.5%
Physician - IP	1.0%	2.5%
Physician - Office	2.0%	3.5%
Specialist	2.0%	3.5%
Emergency Transportation	1.0%	2.5%
Other	3.0%	4.5%
Pharmacy	4.0%	6.6%
TOTAL	1.9%	3.8%

Appendix II(M) Managed Care Assumptions

COA	Managed Care Savings	
	Lower Bound	Upper Bound
Inpatient Hospital	-5.6%	-1.0%
Emergency Room	-15.5%	-3.5%
Home Health	0.0%	0.0%
FQHC & Rural Health Clinic	0.0%	0.0%
Outpatient Hospital	0.0%	0.0%
Laboratory & X-Ray	0.0%	0.0%
Physician - ER	-5.8%	-0.6%
Physician - IP	-3.8%	0.0%
Physician - Office	3.7%	0.6%
Specialist	0.0%	0.0%
Emergency Transportation	0.0%	0.0%
Other	0.0%	0.0%
Pharmacy	0.1%	0.0%
TOTAL	-2.6%	-0.5%

Appendix II(N) Expansion Population Pent-up Demand Factors

COS	Expansion Parents	AwDC
Inpatient Hospital	100.0%	100.0%
Emergency Room	100.0%	100.0%
Home Health	100.0%	100.0%
FQHC & Rural Health Clinic	107.1%	113.3%
Outpatient Hospital	101.9%	103.5%
Laboratory & X-Ray	103.8%	107.0%
Physician	105.0%	109.4%
Specialist	105.0%	109.4%
Emergency Transportation	100.0%	100.0%
DME	106.4%	111.9%
EPSDT	105.0%	109.4%
Pharmacy	107.1%	113.3%

Appendix II(O) Alternative Benefit Plan – Preventive PMPM Adjustments

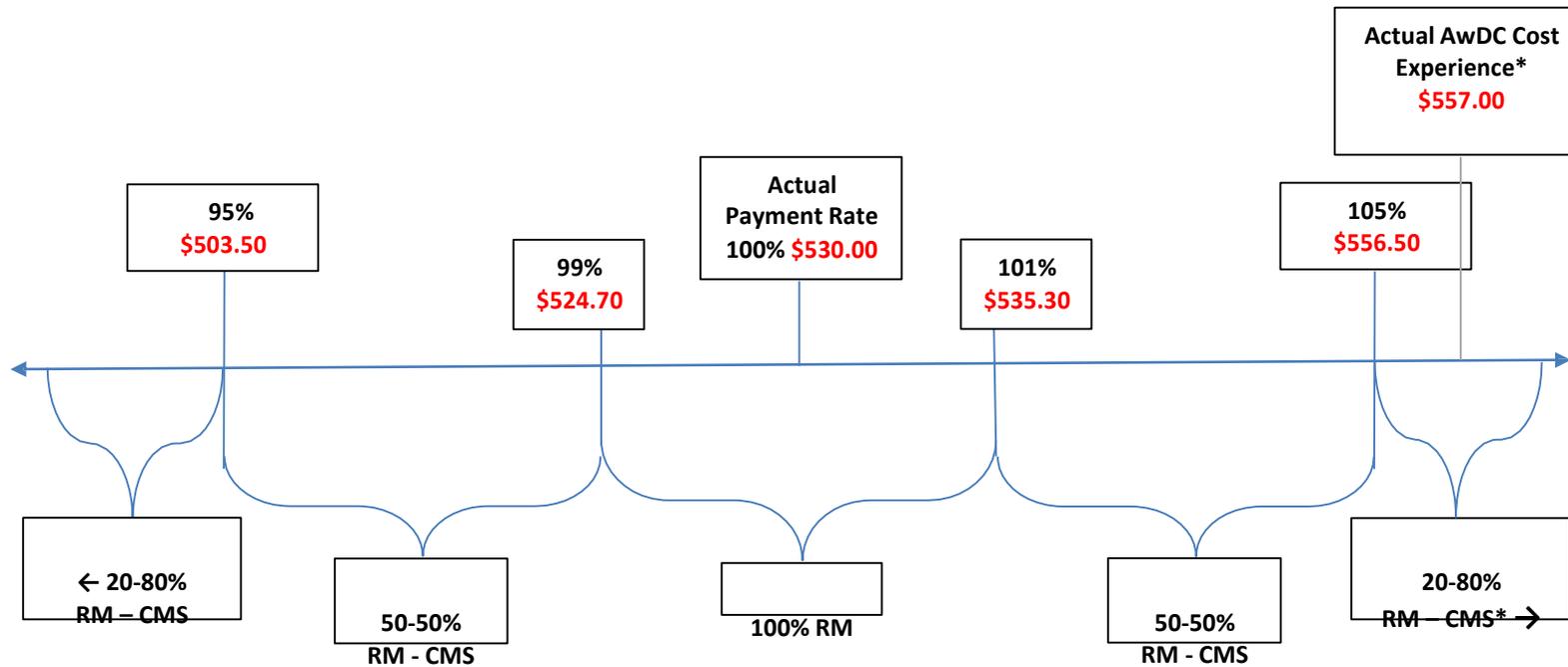
COA	Preventive Services Rate Range	
	Lower Bound	Upper Bound
AFDC/CWP Adults 19+ M	1.0%	2.1%
AFDC/CWP Adults 19+ F	0.9%	1.9%
BC Women	0.2%	0.5%
AND/AB - SSI Non-Dual <45	0.2%	0.4%
AND/AB - SSI Non-Dual 45+	0.2%	0.4%
OAP A – Non-Dual	1.1%	2.3%
OAP B - SSI Non-Dual	0.4%	1.0%
BUYIN Working Adult Disabled	0.4%	1.0%
DUAL	1.7%	3.2%
DUAL - Medicaid Full/Medicare	1.3%	2.5%
Expansion Parent M	N/A	N/A
Expansion Parent F	N/A	N/A
AwDC	N/A	N/A

Appendix II(P) Alternative Benefit Plan – Habilitative PMPM Adjustments

COA	Habilitative Services Rate	
	Lower Bound	Upper Bound
Expansion Parent M	0.1%	0.3%
Expansion Parent F	0.0%	0.2%
AwDC	0.1%	0.4%

Appendix II(Q) AwDC Risk Corridor

Symmetrical AWDC Risk Corridor (Illustrative 1)



*The Department will calculate the Actual AwDC Cost Experience in accordance with standards of actuarial soundness for Medicaid MCOs.

Symmetrical AwDC Risk Corridor Calculations Example (Illustrative 1)

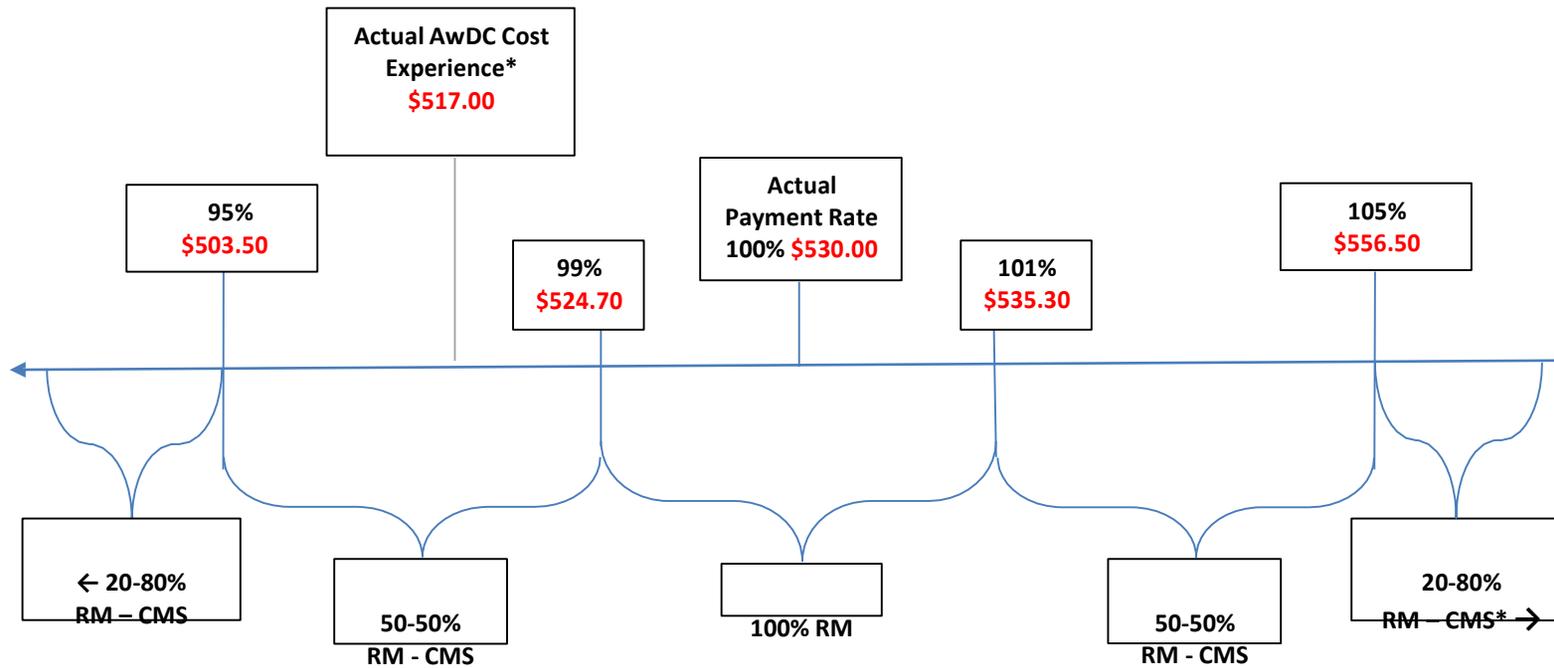
AwDC payment rate	\$530.00
Actual AwDC Cost Experience	\$557.00

MCO Bears Losses For:	
Inner Corridor (100 - 101%)	$(\$535.30 - \$530.00) * 100\% = \mathbf{\$5.30}$
Middle Corridor (101 - 105%)	$(\$556.50 - \$535.30) * 50\% = \mathbf{\$10.60}$
Outer Corridor (105+%)	$(\$557.00 - \$556.50) * 20\% = \mathbf{\$0.10}$
Total Losses for MCO	$\$5.30 + \$10.60 + \$0.10 = \mathbf{\$16.00}$

CMS Reimburses Rocky For:	
Middle Corridor (101 - 105%)	$(\$556.50 - \$535.30) * 50\% = \mathbf{\$10.60}$
Outer Corridor (105+%)	$(\$557.00 - \$556.50) * 80\% = \mathbf{\$0.40}$
Total CMS Reimbursement to MCO	$\$10.60 + \$0.40 = \mathbf{\$11.00}$

Net Loss for MCO:	$\$27.00 - \$11.00 = \mathbf{\$16.00}$
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Symmetrical AwDC Risk Corridor Calculations Example (Illustrative 2)



*The Department will calculate the Actual AwDC Cost Experience in accordance with standards of actuarial soundness for Medicaid MCOs.

Symmetrical AwDC Risk Corridor Calculations Example (Illustrative 2)

AwDC payment rate	\$530.00
Actual AwDC Cost Experience	\$517.00

MCO Gains:	
Inner Corridor (99 - 100%)	$(\$530.00 - \$524.70) * 100\% = \mathbf{\$5.30}$
Middle Corridor (95 - 99%)	$(\$524.70 - \$517.00) * 50\% = \mathbf{\$3.85}$
Total MCO Gain	$\$5.30 + \$3.85 = \mathbf{\$9.15}$

MCO Reimburses CMS:	
Middle Corridor (95 - 99%)	$(\$524.70 - \$517.00) * 50\% = \mathbf{\$3.85}$

Net Gain for MCO:	$\$13.00 - \$3.85 = \mathbf{\$9.15}$
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Appendix II(R) Non-Medical Loading Assumptions

COA	Profit Loading	Rate Range	
		Lower Bound Admin	Upper Bound Admin
AFDC/CWP Adults 19+ M	1.0%	6.7%	4.8%
AFDC/CWP Adults 19+ F	1.0%	6.7%	4.8%
BC Women	1.0%	6.7%	4.8%
AND/AB - SSI Non-Dual <45	1.0%	6.7%	4.8%
AND/AB - SSI Non-Dual 45+	1.0%	6.7%	4.8%
OAP A – Non-Dual	1.0%	6.7%	4.8%
OAP B - SSI Non-Dual	1.0%	6.7%	4.8%
BUYIN Working Adult Disabled	1.0%	6.7%	4.8%
DUAL	1.0%	6.7%	4.8%
DUAL - Medicaid Full/Medicare Partial	1.0%	6.7%	4.8%
Expansion Parent M	1.0%	6.7%	4.8%
Expansion Parent F	1.0%	6.7%	4.8%
AwDC	1.0%	6.7%	4.8%

Appendix III. July 1, 2014 – June 30, 2015 Rate Ranges and Rate Selection

COA	Rate Summary		
	Lower Bound	Rate Selection	Upper Bound
AFDC/CWP Adults 19+ M	\$292.56	\$323.00	\$325.96
AFDC/CWP Adults 19+ F	\$426.34	\$436.00	\$450.18
BC Women	\$873.32	\$965.00	\$1,025.20
AND/AB - SSI Non-Dual <45	\$780.98	\$825.00	\$869.37
AND/AB - SSI Non-Dual 45+	\$1,184.57	\$1,252.00	\$1,319.39
OAP A – Non-Dual	\$590.80	\$643.00	\$693.55
OAP B - SSI Non-Dual	\$1,080.50	\$1,175.00	\$1,268.41
BUYIN Working Adult Disabled	\$998.28	\$1,086.00	\$1,171.89
DUAL	\$95.62	\$103.00	\$110.46
DUAL - Medicaid Full/Medicare	\$242.53	\$263.50	\$284.71
Expansion Parent M	\$301.89	\$323.00	\$340.42
Expansion Parent F	\$388.82	\$436.00	\$438.45
AwDC	\$491.87	\$530.00	\$554.66

EXHIBIT D

FLAT FILE SPECIFICATIONS

MM/COB Paid/Denied Reports			
Name	Description	Type	Size
Claim ID	RMHP Internal Claim Number, 1st 5 digits=Julian date; 6th digit=EDI/Paper Indicator; 7-10=Unique Claim Number; 11-12 = Suffix (00=Original Claim, 01+=Adjusted and/or Split Claim)	Text	12
Line #	Line Item Sequence Number	Number (Integer)	2
Bcat	RMHP Category of Business	Text	4
Mbr Last Name	Member's Last Name	Text	255
Mbr First Name	Member's First Name	Text	255
Mbr ID	Member's RMHP Internal Member ID, 1st 9 digits = Subscriber Social Security Number; 10-11 digits = Individual Member Suffix	Text	255
MD #	Member's Medicaid Number	Text	255
Aid Category	Member's Medicaid Category of Aid	Text	255
DOB	Member's Date of Birth	Date/Time	8
PCP ID	Member's Primary Care Physician Internal RMHP ID	Text	12
PCP Name	Member's Primary Care Physician's Name	Text	255
PCP Ntwk	Member's Primary Care Physician's RMHP Network	Text	12
Svg Prov ID	Servicing Provider Internal RMHP ID	Text	12
Svg Prov Name	Servicing Provider Name	Text	255
Claim From Date	Beginning Date of Service	Date/Time	8
Claim To Date	Ending Date of Service	Date/Time	8
POS	Place of Service Indicator	Text	2
IOE	Inpatient, Outpatient, Emergent Indicator	Text	255
CPT Code	Procedure Code	Text	7
CPT Code Description	Procedure Code Description	Text	120
Rev Code	Revenue Code	Text	4
Rev Code Description	Revenue Code Description	Text	70
Paid DRG	Diagnostic Related Grouping Code	Text	4
Units	Number of Units/Days	Number (Integer)	2
Diagnosis 1	1st Diagnosis Submitted with the Claim	Text	255
Diagnosis 2	2nd Diagnosis Submitted with the Claim	Text	255
Diagnosis 3	3rd Diagnosis Submitted with the Claim	Text	255
Diagnosis 4	4th Diagnosis Submitted with the Claim	Text	255
Total Claim Billed	Total Amount Billed for the Claim	Currency	8
Line Billed	Amount Billed for the Individual Line Number	Currency	8
COB	Amount the Primary Insurance Paid for the Individual Line Number	Currency	8
COB Y/N	Indicator if there was a COB Payment/Denial for the Claim	Text	255
Explanation Code	Adjustment/Denial Reason Code	Text	3
Explanation Code Description	Adjustment/Denial Reason Code Description	Text	40
Received Date	Received Date of the Claim	Date/Time	8
Paid Date	Paid Date of the Claim	Date/Time	8
Report Date	Report Date for tracking purposes	Date/Time	8
Pricing Units	Number Units for pricing	Text	255
Primary Allowed	The Amount Allowed by the Primary Carrier	Currency	8

MD Allowed	Amount Allowed per the State Medicaid Contract	Text	255
Primary Payment	Amount Paid by the Primary Carrier	Currency	8
Secondary Medicaid Payment	The Amount Paid by RMHP after the Primary Payment	Currency	8
Copays	Amount of Medicaid Copay	Text	255
Net Owed	Net Owed Amount to RMHP from HCPF	Text	255
COB Payor	The RMHP identification of the Primary Carrier	Text	9
Paid Y/N	To be completed by HCPF, HCPF Paid Indicator	Text	255
Payment Amount	To be completed by HCPF, HCPF Payment Amount	Text	255
Adj/Denial Reason	To be completed by HCPF, HCPF Adjustment/Denial Reason	Text	255

MM/COB Adjusted Report			
Name	Description	Type	Size
Adjusted Claim ID	RMHP Internal Claim Number, 1st 5 digits=Julian date; 6th digit=EDI/Paper Indicator; 7-10=Unique Claim Number; 11-12 = Suffix (00=Original Claim, 01+=Adjusted and/or Split Claim)	Text	12
Line #	Adjusted Claim Line Item Sequence Number	Number (Integer)	2
Bcat	RMHP Category of Business	Text	4
Mbr Last Name	Member's Last Name	Text	255
Mbr First Name	Member's First Name	Text	255
Mbr ID	Member's RMHP Internal Member ID, 1st 9 digits = Subscriber Social Security Number; 10-11 digits = Individual Member Suffix	Text	255
MD #	Member's Medicaid Number	Text	255
Aid Category	Member's Medicaid Category of Aid	Text	255
DOB	Member's Date of Birth	Date/Time	8
PCP ID	Member's Primary Care Physician Internal RMHP ID	Text	12
PCP Name	Member's Primary Care Physician's Name	Text	255
PCP Ntwk	Member's Primary Care Physician's RMHP Network	Text	12
Svg Prov ID	Servicing Provider Internal RMHP ID	Text	12
Svg Prov Name	Servicing Provider Name	Text	255
Claim From Date	Beginning Date of Service	Date/Time	8
Claim To Date	Ending Date of Service	Date/Time	8
POS	Place of Service Indicator	Text	2
IOE	Inpatient, Outpatient, Emergent Indicator	Text	255
CPT Code	Procedure Code	Text	7
CPT Code Description	Procedure Code Description	Text	120
Rev Code	Revenue Code	Text	4
Rev Code Description	Revenue Code Description	Text	70
Paid DRG	Diagnostic Related Grouping Code	Text	4
Units	Number of Units/Days	Number (Integer)	2
Diagnosis 1	1st Diagnosis Submitted with the Claim	Text	255
Diagnosis 2	2nd Diagnosis Submitted with the Claim	Text	255
Diagnosis 3	3rd Diagnosis Submitted with the Claim	Text	255
Diagnosis 4	4th Diagnosis Submitted with the Claim	Text	255
Total Claim Billed	Total Amount Billed for the Claim	Currency	8
Original Claim ID	Original Claim ID	Text	12
Original Line #	Original Line Item Sequence Number	Number (Integer)	2
Original Line Billed	Original Amount Billed for the Individual Line Number	Currency	8

Original COB Pd	Original Amount the Primary Insurance Paid for the Individual Line Number	Currency	8
Original Paid Date	The Original Paid Date of the Claim	Date/Time	8
Original MD Allowed	Original Amount Allowed per the State Medicaid Contract		
Original MD Copay	Original Amount of Medicaid Copay		
Original Net Owed	Original Net Owed Amount to RMHP from HCPF		
Original Received Date	The Original Received Date of the Claim		
Original State Payment Date	The Original Date of the State Payment to RMHP		
Adjusted Line Billed	Adjusted Amount Billed for the Individual Line Number	Currency	8
Adjusted COB	Adjusted Amount the Primary Insurance Paid for the Individual Line Number	Currency	8
COB Y/N	Indicator if there was a COB Payment/Denial for the Claim	Text	255
Explanation Code	Adjustment/Denial Reason Code	Text	3
Explanation Code Description	Adjustment/Denial Reason Code Description	Text	40
Adjusted Paid Date	The Adjusted (New) Paid Date of the Claim	Date/Time	8
Report Date	Report Date for tracking purposes	Date/Time	8
New Pricing Units	Number Units for pricing	Text	255
New Primary Allowed	The Amount Allowed by the Primary Carrier	Currency	8
New MD Allow	Adjusted Amount Allowed per the State Medicaid Contract	Currency	8
New Primary Payment	Amount Paid by the Primary Carrier	Currency	8
New Secondary Medicaid Payment	The Amount Paid by RMHP after the Primary Payment	Currency	8
New Copays	Adjusted Amount of Medicaid Copay	Text	255
Revised Net Owed	Adjusted Net Owed Amount to RMHP from HCPF	Text	255
Net Difference	Difference between the Original Amount Paid to the Provider and the Adjusted Amount Paid to the Provider	Currency	8
COB Payor	The RMHP identification of the Primary Carrier	Text	9
Paid Y/N	To be completed by HCPF, HCPF Paid Indicator	Text	255
Payment Amount	To be completed by HCPF, HCPF Payment Amount	Text	255
Adj/Denial Reason	To be completed by HCPF, HCPF Adjustment/Denial Reason	Text	255

Pharmacy/MBB Paid/Denied/Adjusted Reports			
Name	Description	Type	Size
Claim ID	RMHP Internal Claim ID	Text	12
Medimpact Claim ID	PBM Claim ID	Text	14
Business Category	Category of Business for RMHP (MD=Medicaid, MM=Medicare/Medicaid)	Text	4

Member Last Name	Member's Last Name	Text	35
Member First Name	Member's First Name	Text	15
Member ID	Member's RMHP Internal Member ID, 1st 9 digits = Subscriber Social Security Number; 10-11 digits = Individual Member Suffix	Text	12
MD #	Member's Medicaid Number	Text	255
Aid Category	Member's Category of Aid	Text	255
DOB	Member's Date of Birth	Date/Time	8
PCP ID	Member's Primary Care Physician Internal RMHP ID	Text	12
PCP Name	Member's Primary Care Physician Name	Text	255
PCP Network	Member's Primary Care Physician Network	Text	12
Svg Provider ID	Servicing Provider Internal RMHP ID	Text	12
Svg Provider Name	Servicing Provider Name	Text	255
Prescribing Provider DEA#	Prescribing Provider's DEA Number	Text	255
Prescribing Provider ID	Prescribing Provider's Internal RMHP ID	Text	12
Prescribing Provider Name	Prescribing Provider's Name	Text	255
Claim From Date	Beginning Date of Service	Date/Time	8
Claim To Date	Ending Date of Service	Date/Time	8
Type	Generic/Preferred Brand/Non-Preferred Brand Indicator	Text	1
Generic Cross Reference Code	Generic Cross Reference Code from PBM	Text	5
Prescription Number	Member's Prescription Number	Text	7
NDC Number	Drug NDC Number	Text	11
HCPC	Drug HCPC Number	Text	255
Prescription Name	Drug Name	Text	30
Days Supply	Number of Days Supply	Number (Double)	8
RX Quantity	Number of Pills (Quantity)	Number (Double)	8
AWP/MAC	AWP/MAC Pricing Indicator	Text	255
Billed Amount	Total Amount Billed for the Pharmacy Claim	Currency	8
Allowed Amount	Amount Allowed for the Pharmacy Claim	Currency	8
Paid Amount	Amount Paid for the Pharmacy Claim	Currency	8
Total Copay	Amount of Copay for the Pharmacy Claim	Currency	8
Tax	Amount of Tax for the Pharmacy Claim	Currency	8
Additional Copay	Amount of Additional Copay Charged for the Pharmacy Claim	Currency	8
Dispensing Fee	Dispensing Fee Charged for the Pharmacy Claim	Currency	8
Provider Pymt	Amount Paid to the Provider for the Pharmacy Claim	Currency	8
Claim Batch Date	Date the Claim was processed through the PBM	Date/Time	8
MD Copay	Amount of the Medicaid Copay	Number (Long)	4
MD Net Owed	Medicaid Net Owed Amount to RMHP	Currency	8
Paid Y/N	HCPF Paid Indicator	Text	255
Payment Amount	HCPF Payment Amount	Text	255
Adj/Denial Reason	HCPF Adjustment/Denial Reason	Text	255

EXHIBIT E
ADMINISTRATIVE AND MEDICAL SERVICES

SECTION 1.0 Administrative and Medical Services

1.1. Administrative services covered: the contractor shall provide or shall arrange to have provided all services specified in, covered services. The contractor shall provide Care Coordination, utilization management and disease state management and pharmacy medical management for members to promote the appropriate and cost effective utilization of covered services. The Contractor shall ensure that any compensation paid for utilization management services do not provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Member. The Contractor shall ensure that the services provided are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished as follows:

1.1.1. Utilization Management / Quality Improvement:

1.1.1.1. Designed to monitor and oversee the quality, appropriateness and delivery of health care services provided by contracted providers for the Contractor's Members. Core concepts of the program are to improve health care outcomes; determine patterns of over and underutilization of tests, procedures and services; monitor issues and data associated with adverse determinations; and implement improvements to the health care services and delivery.

1.1.1.2. Utilization Management involves:

1.1.1.3. Prospective, concurrent, and retrospective review

1.1.1.4. Preauthorization system

1.1.1.5. Medical Management Team oversight

1.1.1.6. Transplant coordination

1.1.1.7. Onsite reviews

1.1.1.8. Discharge planning

1.1.1.9. Case management

1.1.1.10. Appeals and Grievances

1.1.2. Disease State Management Programs:

1.1.2.1. Designed to improve the health status of the entire identified disease/condition population. These programs include Diabetes, Asthma, High Risk OB, Depression and secondary prevention of Coronary Heart Disease.

1.1.2.1.1. Accomplished by:

1.1.2.1.1.1. Identification and tracking (internal and external operations)

- 1.1.2.1.2. Stratification by:
 - 1.1.2.1.2.1. Population Management. and one-to-one case management
 - 1.1.2.1.2.2. Initiated by imported lab values, patient assessment results and physician input.
- 1.1.2.1.3. Measurement and Reporting by:
 - 1.1.2.1.3.1. Utilization, process improvement and clinical outcomes
- 1.1.3. Pharmacy Medical Management Services:
 - 1.1.3.1. Designed for the most appropriate pharmaceutical therapies at the best cost through rebate contracting.
 - 1.1.3.1.1. Accomplished by:
 - 1.1.3.1.1.1. Generic substitution
 - 1.1.3.1.1.2. Physician and Pharmacist Education
 - 1.1.3.1.2. Clinical Functions:
 - 1.1.3.1.2.1. Analysis of detailed drug information updates
 - 1.1.3.1.2.2. Understanding potential drug interactions
 - 1.1.3.1.2.3. Drug uses and dosages
 - 1.1.3.1.2.4. Physician consulting
 - 1.1.3.1.3. Operational Functions:
 - 1.1.3.1.3.1. Pharmacy help desk
 - 1.1.3.1.3.2. Provider call center
 - 1.1.3.1.3.3. Coordination needs for claims

EXHIBIT F
COVERED BEHAVIORAL HEALTH PROCEDURE CODES

Proc Code	Full description of the procedure codes
00104	Anesthesia for electroconvulsive therapy
90785	Interactive complexity (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient and/or family member
90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90834	Psychotherapy, 45 minutes with patient and/or family member
90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90837	Psychotherapy, 60 minutes with patient and/or family
90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90839	Psychotherapy for crisis, first 60 minutes
90840	Psychotherapy for crisis, each additional 30 minutes (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90846	Family psychotherapy (without the patient present)
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90870	Electroconvulsive therapy (includes necessary monitoring)
90875	Individual psycho-physiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 30 minutes
90876	Individual psycho-physiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 45 minutes
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
96101	Psychological testing (includes psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96102	Psychological testing (includes psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face

96103	Psychological testing administered by a computer, with qualified health care professional interpretation and report.
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96118	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96119	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96120	Neuropsychological testing by a computer, with qualified health care professional interpretation and report.
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug) subcutaneous or intramuscular
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
98966	Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
98967	Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
98968	Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99221	Initial Hospital Care Low Complexity
99222	Initial Hospital Care Moderate Complexity
99223	Initial Hospital Care High Complexity
99231	Subsequent Hospital Care Low Complexity
99232	Subsequent Hospital Care Moderate Complexity
99233	Subsequent Hospital Care High Complexity
99238	Hospital Discharge Day Management/30 minutes
99239	Discharge day management; more than 30 minutes
99251	Initial Inpatient Consultation/20 minutes

99252	Initial Inpatient Consultation/40 minutes
99253	Initial Inpatient Consultation/55 minutes
99254	Initial Inpatient Consultation/80 minutes
99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by non-physician qualified health care professional.
99367	Medical team conference, with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician.
99368	Medical team conference with interdisciplinary team, patient and/or family not present, 30 minutes or more, participation by non-physician qualified health care professional
99441	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion
99442	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 11-20 minutes of medical discussion
99443	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 21-30 minutes of medical discussion
G0176	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more).
*H0001	Alcohol and/or drug assessment
H0002	Behavioral health screening to determine eligibility for admission to treatment program
*H0004	Behavioral health counseling and therapy, per 15 minutes
*H0005	Alcohol and/or drug services; group counseling by a clinician
*H0006	Alcohol and/or drug services; case management (targeted)
H0017	Behavioral health; residential (hospital residential treatment program), without room and board, per diem
H0018	Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem
H0019	Behavioral health; long-term residential (nonmedical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
*H0020	Medication Assisted Treatment
H0023	Behavioral health outreach service (planned approach to reach a targeted population)
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
H0031	Mental health assessment, by non-physician
H0032	Mental health service plan development by non-physician
H0033	Oral medication administration, direct observation
H0034	Medication training and support, per 15 minutes
H0035	Mental health partial hospitalization, treatment, less than 24 hours
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes
H0037	Community psychiatric supportive treatment program, per diem

*H0038	Self-help/peer services, per 15 minutes
H0039	Assertive community treatment, face-to-face, per 15 minutes
H0040	Assertive community treatment program, per diem
H0043	Supported housing, per diem
H0044	Supported housing, per month
H0045	Respite care services, not in the home, per diem
H1011	Family assessment by licensed behavioral health professional for state defined purposes
H2000	Comprehensive multidisciplinary evaluation
H2001	Rehabilitation program, per 1/2 day
H2011	Crisis intervention service, per 15 minutes
H2012	Behavioral health day treatment, per hour
H2014	Skills training and development, per 15 minutes
H2015	Comprehensive community support services, per 15 minutes. Long definition: The purpose of Comprehensive Community Support Services is to coordinate and provide services and resources to individuals/families necessary to promote recovery, rehabilitation and resiliency. Comprehensive Community Support Services identifies and addresses the barriers that impede the development of skills necessary for independent functioning in the community; as well as strengths, which may aid the individual or family in the recovery or resiliency process. Community support activities address goals specifically in the following areas: independent living; learning; working; socializing and recreation. Comprehensive Community Support Services also include supporting an individual and family in crisis situations; and providing individual interventions to develop or enhance an individual's ability to make informed and independent choices.
H2016	Comprehensive community support services, per diem
H2017	Psychosocial rehabilitation services, per 15 minutes
H2018	Psychosocial rehabilitation services, per diem
H2021	Community-based wrap-around services, per 15 minutes
H2022	Community-based wrap-around services, per diem
H2023	Supported employment, per 15 minutes
H2024	Supported employment, per diem
H2025	Ongoing support to maintain employment, per 15 minutes
H2026	Ongoing support to maintain employment, per diem
H2027	Psychoeducational service, per 15 minutes
H2030	Mental health clubhouse services, per 15 minutes
H2031	Mental health clubhouse services, per diem
H2032	Activity therapy, per 15 minutes
H2033	Multi-systemic therapy for juveniles, per 15 minutes
M0064	Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, and personality disorders
*S3005	Safety assessment including suicidal ideation and other behavioral health issues
S5150	Unskilled respite care, not hospice; per 15 minutes
S5151	Unskilled respite care, not hospice; per diem
*S9445	Drug screening and monitoring
S9453	Smoking cessation classes, non-physician provider, per session
S9454	Stress management classes, non-physician provider, per session
S9480	Intensive outpatient psychiatric services, per diem
S9485	Crisis intervention mental health services, per diem
T1005	Respite care services, up to 15 minutes
*T1007	Physical assessment of detoxification progression including vital signs monitoring

T1016	Case management, each 15 minutes
T1017	Targeted case management, each 15 minutes
*T1019	Provision of daily living needs including hydration, nutrition, cleanliness and toiletry for clients
*T1023	Level of motivation assessment for treatment evaluation

*Denotes services that have been approved by the Joint Budget Committee (JBC) for inclusion in the substance use disorder benefit.

Please note: The Department and its Contractors will continue to refine and update the covered procedures list on an ongoing basis.

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The below list of Evaluation and Management codes are covered by the BHOs when they are billed in conjunction with a psychotherapy add-on from the above list or when used for the purposes of medication management with minimal psychotherapy provided by a prescriber from the BHO network.

Proc Code	Full description of the procedure codes
99201	Office or other outpatient visit, new patient/ 10 minutes
99202	Office or other outpatient visit, new patient/ 20 minutes
99203	Office or other outpatient visit, new patient/ 30 minutes
99204	Office or other outpatient visit, new patient/ 45 minutes
99205	Office or other outpatient visit, new patient/ 60 minutes
99211	Office or other outpatient visit, established patient/ 5 minutes
99212	Office or other outpatient visit, established patient/10 minutes
99213	Office or other outpatient visit, established patient/ 15 minutes
99214	Office or other outpatient visit, established patient/ 25 minutes
99215	Office or other outpatient visit, established patient/ 40 minutes
99217	Observation care discharge day management
99218	Initial observation / 30 minutes
99219	Initial observation care/ 50 minutes
99220	Initial observation care/ 70 minutes
99224	Subsequent observation care/ 15 minutes
99225	Subsequent observation care/ 25 minutes
99226	Subsequent observation care/ 35 minutes
99234	Observation or inpatient hospital care, patient admitted and discharged on same date of service, 40 minutes
99235	Observation or inpatient hospital care, patient admitted and discharged on same date of service/50 minutes
99236	Observation or inpatient hospital care, patient admitted and discharged on same date of service/ 55 minutes
99241	Office consultation/ 15 minutes
99242	Office consultation/ 30 minutes
99243	Office consultation/ 40 minutes
99244	Office consultation/ 60 minutes
99245	Office consultation/ 80 minutes
99255	Initial inpatient consultation/ 110 minutes.
99304	Initial nursing facility care/per day/ 25 minutes spent at bedside or on patient floor/unit
99305	Initial nursing facility care/per day/ 35 minutes spent at bedside or on patient floor/unit
99306	Initial nursing facility care/per day/ 45 minutes spent at bedside or on patient floor/unit
99307	Subsequent nursing facility care/per day/ 10 minutes spent at bedside or on patient floor/unit
99308	Subsequent nursing facility care/per day/ 15 minutes spent at bedside or on patient floor/unit
99309	Subsequent nursing facility care/per day/ 25 minutes spent at bedside or on patient floor/unit
99310	Subsequent nursing facility care/per day/ 35 minutes spent at bedside or on patient floor/unit
99315	Nursing facility discharge day management/ 30 minutes or less
99316	Nursing facility discharge day management; more than 30 minutes
99318	Annual nursing facility assessment/ 30 minutes spent at bedside or on patient floor/unit

99324	Domiciliary or rest home visit, new patient/ 20 minutes
99325	Domiciliary or rest home visit, new patient/ 30 minutes
99326	Domiciliary or rest home visit, new patient/ 45 minutes
99327	Domiciliary or rest home visit, new patient/ 60 minutes
99328	Domiciliary or rest home visit, new patient/ 75 minutes
99334	Domiciliary or rest home visit, established patient/ 15 minutes
99335	Domiciliary or rest home visit, established patient/ 25 minutes
99336	Domiciliary or rest home visit, established patient/ 40 minutes
99337	Domiciliary or rest home visit, established patient/ 60 minutes
99341	Home visit, new patient/20 minutes
99342	Home visit, new patient/30 minutes
99343	Home visit, new patient/45 minutes
99344	Home visit, new patient/60 minutes
99345	Home visit, new patient/75 minutes
99347	Home visit, established patient/15 minutes
99348	Home visit, established patient/25 minutes
99349	Home visit, established patient/40 minutes
99350	Home visit, established patient/60 minutes

Please Note: This list of covered procedures is to be used as a guideline rather than a contractual requirement. The Department and its Contractors will continue to refine and update the covered procedures list on an ongoing basis.

EXHIBIT G
CONTRACTOR DISCLOSURE TEMPLATE

Insert the Contractor's name and address: _____

Insert the name and address of any person with an ownership or control interest in the Contractor: _____

Insert the date of birth and social security number for any individual with an ownership or control interest in the Contractor: _____

Insert the tax identification number of any corporate entity with an ownership or control interest in the Contractor or in any Subcontractor in which the Contractor has a five percent (5%) or greater interest: _____

State whether any person with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child or sibling: _____

State whether any person with an ownership or control interest in the any Subcontractor in which the Contractor has a five percent (5%) or greater interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child or sibling: _____

Insert the name of any other entity required to disclose under 42 CFR 455.104 in which any owner of the Contractor has an ownership or control interest: _____

The name, address, date of birth and Social Security Number of any managing employee of the Contractor: _____

EXHIBIT H

ENCOUNTER DATA SPECIFICATIONS

SECTION 1.0 ENCOUNTER CLAIMS DATA EDITS

- 1.1. The MMIS will edit encounter claims for accuracy and reasonableness of data. The edits used may change as the volume and accuracy of data increases. The Contractor can obtain a current list of edits by contacting the Department or going to the Department's website.

SECTION 2.0 ENCOUNTER CLAIMS DATA TYPES

2.1. Adjudicated Encounter Claims Data

- 2.1.1. Adjudicated encounter claims are encounters that have been accepted by the MMIS system edits as provisionally correct.
- 2.1.2. If the Department discovers errors with previously adjudicated claims resulting from a federal or state mandate or request that requires the completeness and accuracy of the Encounter Claims Data, the Contractor shall be required to correct the error.

2.2. Rejected Encounter Claims Data

- 2.2.1. Rejected Encounter Claims Data are encounters that fail electronic claims capture (ECC) edits. These claims are not received into MMIS and will be reported to the Contractor upon failure of ECC.

2.3. Denied Encounter Claims Data

- 2.3.1. Denied Encounter Claims Data are encounter claims that fail to process correctly in the MMIS because of content that is missing, erroneous, or does not meet Medicaid rules. These claims are retained in the MMIS with a claim status equal to deny and will be reported to the Contractor on a routine basis.

2.4. Data Set Format Requirements

- 2.4.1. The Contractor shall submit all Encounter Claims Data for MMIS in a format to be specified by the Department.
- 2.4.2. Detailed format information for the ANSI 837 transaction is available at <http://www.wpc-edi.com>. HIPAA transaction data guides to prepare systems to work with the Colorado Medicaid program and detail acceptable Colorado Program values can be found at <http://www.chcpf.state.co.us>.
- 2.4.3. A detailed format of the HIPAA transaction data guide for Pharmacy submissions is available on the Department's website found at <http://www.chcpf.state.co.us>.
- 2.4.4. The Department reserves the right to change the format requirements at any time, following consultation with the Contractor. The Department, however, retains the right to make the final decision regarding format submission requirements.
- 2.4.5. The Contractor shall take necessary measures to ensure the:
- 2.4.6. Accuracy of all required fields;

- 2.4.6.1. Completeness of Encounter Claims Data submitted;
- 2.4.6.2. Presence of Medical Record documentation for each encounter claim;
- 2.4.6.3. Submitted data include paid claims identified in this section of the Contract;
- 2.4.6.4. Submitted data excludes interim, serial and late billings or claims in appeal status; and,
- 2.4.6.5. Submitted data include the most current version of adjusted claims.
- 2.4.7. The Contractor shall review and remain in compliance with these criteria each year by reviewing and documenting at least one statistically valid sample of encounter claims submitted to the Department.

2.5. Encounter Provider Identification

- 2.5.1. Encounter Claims Data for Covered Services provided by Medicaid Providers shall contain the Provider's Medicaid Provider ID for providers that receive reimbursement (in whole or part) on a provider specific cost basis through the MMIS. This has been determined to be for all Institutional claims submitted using the 837I format. The Contractor shall use the Department supplied pseudo-numbers to identify all other Providers who bill Professional claims using the 837P format.
- 2.5.2. Pharmacy Encounter Claims Data shall contain the Pharmacy's NPI number. The Contractor shall use the Department supplied pseudo-number to identify Providers who are not actively contracted with Colorado Medicaid.

2.6. Encounter Claims Data Transmissions

- 2.6.1. The Contractor shall submit all Encounter Claims Data directly to the MMIS, via electronic transmission.
- 2.6.2. The Department in addition to the MMIS supplied 425 remittance report shall provide a quarterly report detailing line level transaction activity for each claim accepted into the MMIS to the Contractor of all Encounter Claims Data received via electronic transmission.

EXHIBIT I

MEDICAL HOME MODEL PRINCIPLES

SECTION 1.0 The Following are the Principles of the Medical Home Model

- 1.1. The care provided is:
 - 1.1.1. Member/family-centered;
 - 1.1.2. Whole-person oriented and comprehensive;
 - 1.1.3. Coordinated and integrated;
 - 1.1.4. Provided in partnership with the Member and promotes Member self-management;
 - 1.1.5. Outcomes-focused;
 - 1.1.6. Consistently provided by the same provider as often as possible so a trusting relationship can develop; and
 - 1.1.7. Provided in a culturally competent and linguistically sensitive manner.
- 1.2. A PCMP that is:
 - 1.2.1. Accessible, aiming to meet high access-to-care standards such as:
 - 1.2.1.1. Twenty-four (24) hour, seven (7) days a week phone coverage with access to a clinician that can triage;
 - 1.2.1.2. Extended daytime and weekend hours;
 - 1.2.1.3. Appointment scheduling within:
 - 1.2.1.3.1. 48 hours for urgent care,
 - 1.2.1.3.2. 10 days for symptomatic, non-urgent care
 - 1.2.1.3.3. 45 days for non-symptomatic routine care; and
 - 1.2.1.4. Short waiting times in reception area.
 - 1.2.1.5. Committed to operational and fiscal efficiency.
 - 1.2.1.6. Able and willing to coordinate with its associated RCCO on medical management, Care Coordination, and case management of Members.
 - 1.2.1.7. Committed to initiating and tracking continuous performance and process improvement activities, such as improving tracking and follow-up on diagnostic tests, improving care transitions, and improving Care Coordination with specialists and other Medicaid providers, etc.
 - 1.2.1.8. Willing to use proven practice and process improvement tools (assessments, visit agendas, screenings, Member self-management tools and plans, etc.).
 - 1.2.1.9. Willing to spend the time to teach Members about their health conditions and the appropriate use of the health care system as well as inspire confidence and empowerment in Members' health care ownership.

- 1.2.1.10. Focused on fostering a culture of constant improvement and continuous learning.
- 1.2.1.11. Willing to accept accountability for outcomes and the Member family experience.
- 1.2.1.12. Able to give Members and designated family members easy access to their medical records when requested.
- 1.2.1.13. Committed to working as a partner with the RCCO in providing the highest level of care to Members.

EXHIBIT J
SERIOUS REPORTABLE OR NEVER EVENTS

SECTION 1.0 SERIOUS REPORTABLE OR NEVER EVENTS

- 1.1. Effective for inpatient hospital claims with discharge dates on or after October 1, 2009, reimbursement will not be increased for additional costs resulting from the hospital-acquired conditions and serious reportable events identified below:
 - 1.1.1. Foreign object inadvertently left in patient after surgery;
 - 1.1.2. Death/disability associated with incompatible blood;
 - 1.1.3. Stage 3 or 4 pressure ulcers after admission;
 - 1.1.4. Hospital-acquired injuries: fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes;
 - 1.1.5. Catheter-associated urinary tract infection;
 - 1.1.6. Vascular catheter-associated infection;
 - 1.1.7. Mediastinitis after coronary artery bypass graft surgery;
 - 1.1.8. Manifestations of poor glycemic control;
 - 1.1.9. Surgical site infection following certain orthopedic procedures;
 - 1.1.10. Surgical site infection following bariatric surgery for obesity; and
 - 1.1.11. Deep vein thrombosis & pulmonary embolism following certain orthopedic procedures.
- 1.2. In addition, no payment will be made for hospitalizations for:
 - 1.2.1. Surgery performed on the wrong body part;
 - 1.2.2. Surgery performed on the wrong patient; or
 - 1.2.3. Wrong surgical procedure on a patient.

EXHIBIT K
MEMBER INFORMATION

SECTION 1.0 MEMBER INFORMATION

1.1. INFORMATION PROVIDED TO MEMBERS

- 1.1.1. The Contractor shall ensure that all of the following information is contained in its Member handbook and is provided to all Members:
 - 1.1.1.1. The Member's disenrollment rights, including the disenrollment timelines contained in Exhibit A, Statement of Work.
 - 1.1.1.2. The Member's right to disenroll or change providers, at any time for cause, as described in Exhibit A, Statement of Work.
 - 1.1.1.3. The Member's right to request and obtain Member information.
 - 1.1.1.3.1. The Contractor shall distribute this Member information within a reasonable timeframe from the Member's request to obtain this information.
- 1.1.2. The Contractor shall ensure that the following information is available to Members, as required by 42 CFR 438.10:
 - 1.1.2.1. Names, locations, telephone numbers of, and non-English languages spoken by current contracted Providers in the Service Area, including identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists and hospitals.
 - 1.1.2.2. Any restrictions on the Member's freedom of choice among network providers.
 - 1.1.2.3. Member rights and protections, as specified in § 438.100.
 - 1.1.2.4. Information on grievance and fair hearing procedures and the information specified in 42 CFR 438.10(g)(1).
 - 1.1.2.5. The amount, duration and scope of benefits available under this Contract in sufficient detail to ensure that Members understand the benefits to which they are entitled.
 - 1.1.2.6. Procedures for obtaining benefits, including authorization requirements.
 - 1.1.2.7. The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers.
 - 1.1.2.8. The extent to which, and how, after-hours and emergency coverage are provided, including:
 - 1.1.2.8.1. What constitutes emergency medical condition, emergency services, and poststabilization services, with reference to the definitions in 42 CFR 438.114(a).
 - 1.1.2.8.2. The fact that prior authorization is not required for emergency services.

- 1.1.2.8.3. The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.
- 1.1.2.8.4. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and poststabilization services covered under this Contract.
- 1.1.2.8.5. The fact that, subject to the provisions of this section, the Member has a right to use any hospital or other setting for emergency care.
- 1.1.2.9. The poststabilization care services rules set forth at 42 CFR 422.113(c).
- 1.1.2.10. Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.
- 1.1.2.11. All cost sharing information applicable to Members.
- 1.1.2.12. How and where to access any benefits that are available under the State plan but are not covered under this Contract, including any cost sharing, and how transportation is provided.
 - 1.1.2.12.1. For a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service. The Department will provide information on how and where to obtain the service.
- 1.1.2.13. Grievance, appeal and fair hearing procedures and timeframes, as provided in 42 CFR 438.400 through 438.424, in a Department-approved description that includes all of the following:
 - 1.1.2.13.1. For Department fair hearing:
 - 1.1.2.13.1.1. The right to hearing;
 - 1.1.2.13.1.2. The method for obtaining a hearing; and
 - 1.1.2.13.1.3. The rules that govern representation at the hearing.
 - 1.1.2.13.2. The right to file grievances and appeals.
 - 1.1.2.13.3. The requirements and timeframes for filing a grievance or appeal
 - 1.1.2.13.4. The availability of assistance in the filing process
 - 1.1.2.13.5. The toll-free numbers that the Member can use to file a grievance or an appeal by phone.
 - 1.1.2.13.6. The fact that, when requested by the Member:
 - 1.1.2.13.6.1. Benefits will continue if the Member files an appeal or a request for Department fair hearing within the timeframes specified for filing; and
 - 1.1.2.13.6.2. The Member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the Member.
 - 1.1.2.13.7. Any appeal rights that the Department chooses to make available to providers to challenge the failure of the organization to cover a service.

- 1.1.2.13.8. Advance Directives, as set forth in 42 CFR 438.6(i)(1).
- 1.1.2.13.9. Additional information that is available upon request, including the following:
 - 1.1.2.13.9.1. Information on the structure and operation of the Contractor.
 - 1.1.2.13.10. Physician incentive plans as set forth in 42 CFR 438.6(h).
- 1.1.2.14. Any cost sharing or co-pays that the Member is responsible for in relation to the receipt of a Covered service.
 - 1.1.2.14.1. All cost sharing and co-pays shall be implemented and imposed in accordance with 42 CFR 447.50 through 42 CFR 447.60.
- 1.1.3. The Contractor shall notify all Members, at least once a year, of their right to request and obtain the information required by 42 CFR 438.10.

EXHIBIT L
FAMILY PLANNING DOCUMENTATION METHODOLOGY AND
REPORTING

SECTION 1.0 FAMILY PLANNING

1.1. INTRODUCTION

- 1.1.1. Family planning services are collected and documented on a monthly basis from claims adjudicated through the MMIS in the following categories:
 - 1.1.1.1. Pharmacy Claims
 - 1.1.1.2. 837P Provider Claims
 - 1.1.1.3. 837I Institutional Claims
- 1.1.2. Detail for each claims category is provided below.

1.2. PHARMACY CLAIMS

- 1.2.1. For each reporting month, pharmacy claims with dates of payment for that month are pulled from data warehouse (DSS) using SQL queries in TOAD software. Only oral contraceptives, topical contraceptives, and implantable contraceptives are included (as indicated in the attached document.) The Header Claim Payment amounts for these claims are summed and included in the final report.

1.3. FAMILY PLANNING CLAIMS

- 1.3.1. Claims data are pulled using SQL queries in TOAD software for each reporting month with dates of payment in that month. For this part of the analysis, Institutional claims are excluded (Claim Types B, D, M, O, C and J). Claim lines having a header principal diagnosis code, a line diagnosis code 1, and a line procedure code all indicating family planning are identified. These claim lines have no additional diagnosis information except for a principal diagnosis and a line diagnoses code 1. The costs associated with these claim lines are summed and included in the final report.

1.3.2. Professional Claim lines not classified as family planning based on the methodology above are then reviewed solely on line item diagnosis information. Only claims lines with a header diagnosis code, or a line diagnosis code 1, or a procedure code indicating family planning are considered. Professional claims can have up to 4 diagnosis codes on each line. If any of the four line item diagnosis codes indicate family planning, some portion of the claim line reimbursed amount is allocated as family planning dollars. This allocation process involves weighting the diagnosis codes as follows. *Line diagnosis code 1* is weighted a 4, *line diagnosis code 2* is weighted a 3, *line diagnosis code 3* is weighted a 2, and *line diagnosis code 4* is weighted a 1. Each diagnosis code is identified as either a family planning diagnosis or a non-family planning diagnosis. For each claim line the weights for family planning diagnoses are summed and divided by the sum of the weights for all of the diagnosis codes. The resulting percentage is multiplied by the line reimbursement amount to determine the family planning dollars for that claim line. These amounts are then summed and included in the final report.

1.4. FAMILY PLANNING INSTITUTIONAL CLAIMS

1.4.1. Institutional Claims (Claim Types B, D, M, O, C and J) are pulled from data warehouse (DSS) each reporting month with dates of payment in that month. All of the Surgical Codes and all of the Diagnosis Codes associated with these claims are also pulled. The Institutional Claims with the first Surgery Code listed on the claim indicating a Family Planning surgery are identified (see attached list of Family Planning Surgery codes). The subset of these claims that are for Outpatient services (Claim Type “C”) are identified, and the average cost for each of these claims calculated. Then the total number of Inpatient and Outpatient Claims are multiplied by the average cost for Outpatient Claims with a “primary” procedure indicating family planning identified above (family planning surgeries). Rather than include the entire inpatient claim for family planning, only an amount equivalent to the average outpatient surgery is considered. These amounts are then summed and included in the final report.

1.4.2. Institutional Claims without any dollars attributed to family planning based on the methodology above are then reviewed based solely on diagnosis information. Each Institutional Claim can have up to a maximum of 9 diagnosis codes. If any of the nine diagnosis codes for that Institutional Claim indicate family planning, some portion of the claim payment amount is allocated as family planning dollars. This allocation process involves weighting the diagnosis codes similar to the method described for the Professional claims above. Each diagnosis code is identified as either a family planning diagnosis or a non-family planning diagnosis. For each Institutional Claim the weights for family planning diagnoses are summed and divided by the sum of the weights for all of the diagnosis codes. The resulting percentage is multiplied by the Header Payment amount to determine the family planning dollars for that claim. These amounts are then summed and included in the final report.

1.5. COST ALLOCATION FOR ACCOUNTING

- 1.5.1. Family Planning dollars identified by the methods above are then summarized by Category of Service and Subcategory of Service. The service categories are classified into appropriate accounting codes based on the attached crosswalk. The final coded amounts are forwarded to the Accounting Section where they are reclassified from 50% to 90% for reporting via the CMS-64.

EXHIBIT M CARE COORDINATION LEVELS

The Contractor shall provide or arrange for care Coordination Services for all members, through an identification and assessment process that reflects population-wide and member-specific needs gaps in health, behavioral and social supports at any given time. The Contractor shall be accountable for the coordination of care for all members, but will provide resources, technical support and oversight to facilitate the performance of Care Coordination in advanced PCMP and Community Care Team (CCT) settings when deemed appropriate by the Contractor. In no case shall the performance of Care Coordination functions by a PCMP or CCT reduce or substitute ultimate accountability for appropriate Care Coordination functions by the Contractor. Additionally the Contractor shall support the effective information sharing and alignment of Care Coordination activities across multiple clinical and community agency settings. The format for assessment and documentation in PCMP and CCT settings may vary from the Contractor's own system (as shown below), but all elements of the Contractor's assessment, care planning and care management process will be actively monitored by the Contractor. Contractor monitoring will entail regular, ground-level assessment by Contractor personnel, through Quality Improvement Advisors and other resources; regular, qualitative reporting through practice narrative updates; member record audits and quantitative operations and outcomes analysis performed by the Contractor.

Levels of Care Coordination:

The Contractor has implemented multi-level Care Coordination criteria, and will utilize these operational definitions to support the System of Care. The levels are not mutually exclusive, and may be applied (simultaneously) at times in the Contractor's support for the community System of Care.

Additionally, the Contractor's Care Coordination activities shall not be limited or circumscribed by these Levels of Care – or by any single diagnostic, functional, behavioral, social or cognitive dimension of need. The Levels of Care categories support organization, integration, data sharing and reporting functions across multiple partnerships within the Contractor's service area. Members support activities within the scope of the Contractor's Care Coordination plan include, but are not limited to:

- Home visits
- Transportation and accompanying Members to appointments
- Accessing financial, human services and community programs,
- Assistance with nutrition, grocery shopping, housing and domestic safety
- Supported transitions from corrections, foster care, and similar programs
- Expedited access to mental health and substance abuse treatment services

These services will be made available to Members upon request, upon identification of needs through outbound contact activities conducted by the Contractor upon enrollment, and pursuant to coordinated assessment and information sharing protocols implemented among the Contractor and community partners. These partners include, but are not limited to:

- Single Entry Points
- Adult Protective Services
- Health Communities / EPSDT
- Community-Centered Boards
- Community Health Centers
- Independent Living Centers
- Community Mental Health Centers
- Senior Assistance Programs
- Local Public Health Agencies
- County Corrections
- County Departments of Human Services
- Community Care Coordination Teams
- PCMPs, Hospitals and Specialty-care providers

The Department will work with the Contractor to assist in the development of data sharing mechanisms to support these activities, including functional / LTSS assessment and placement data, over the course of this agreement.

Level 1 — Preventative Care, Wellness Care

Members receive a call to help establish a primary care physician (PCP) or practice. Members receive reminders for annual and preventative care screenings.

Level 2 — Well-controlled disease process; Member with good self-management skills

Single, well-managed chronic disease and support for the Member to continue to self-manage their disease process.

Level 3a — Moderately well-managed Disease Process (controlled and uncontrolled periods, referrals to specialists not required)

Includes more robust support for the Member to self-manage their disease process. This may include community classes, Care Coordinator phone calls, or consults with ancillary professionals (i.e. a nutritionist) in practice settings.

Level 3b — Moderately managed Disease Process (controlled and uncontrolled periods and referrals to specialists required)

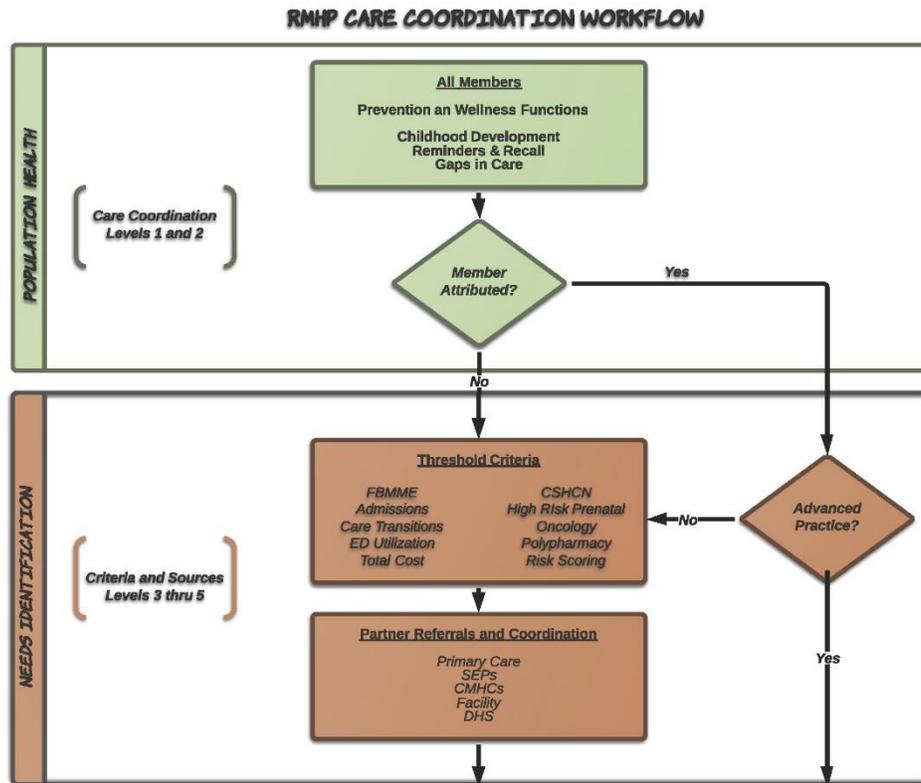
Includes more robust support for the Member to self-manage their disease process as in Level 3a, as well as active engagement with the Member and their providers to coordinate care among all providers.

Level 4 — Complex Outpatient Care Coordination — Poorly controlled disease process

Typically, Members at this level will have multiple morbidities and have multiple barriers accessing the appropriate care, in the appropriate place and time. Locally based Care Coordinators will build trust-based patient-centered relationships to facilitate the Member's ability to effectively navigate the health care system and facilitate the numerous providers and Care Coordinators in contact with the Member to effectively care for the Member. Care Coordinators focus on the immediate needs of the Member.

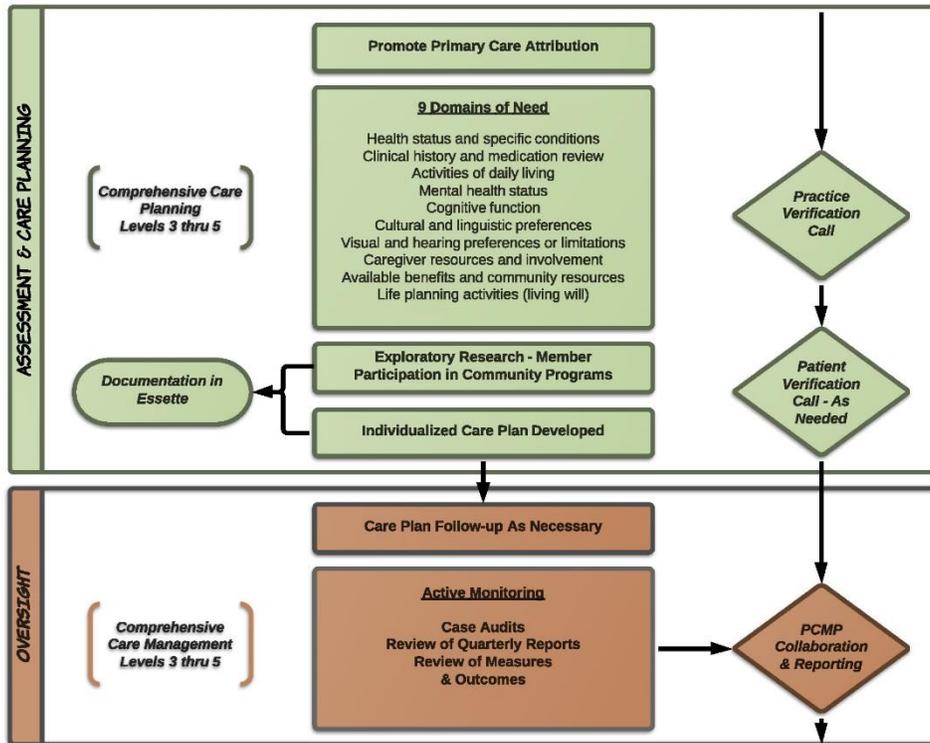
Level 5 — Transitions of Care

Transition of Care - In the course of an acute exacerbation of an illness, a Member might receive care from a PCMP or specialist in an outpatient setting, then transition to a hospital admission before moving on to yet another care team at a skilled nursing facility. Finally, the Member might return home, where he or she would receive care from a Home Health nurse. Each of these shifts from care providers and settings is defined as a care transition and local Care Coordinators will work with the Member to manage these transitions.

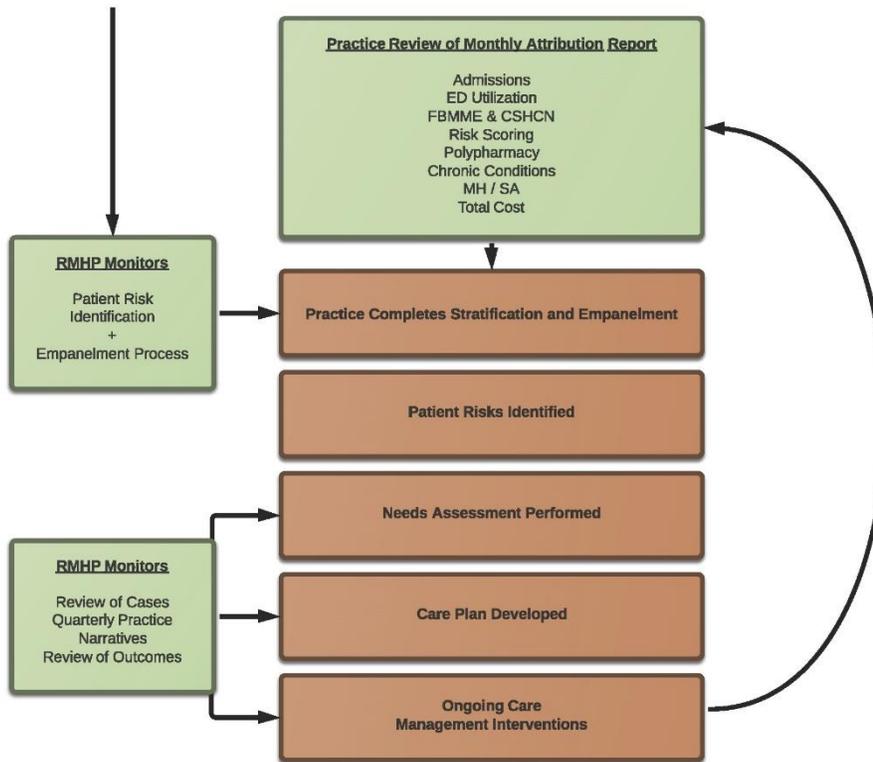


Care Coordination Workflow and Community System of Care :

The Contractor's assessment criteria, care planning, care management, reporting and oversight process shall reflect the Workflow and community System of Care workflow set forth below:



ADVANCED PRACTICE WORKFLOW



MLR Calculation Example

OAP A - Non Dual		OAP B- SSI NonDual		AND/AB - SSI NonDual <45		AND/ AB - SSI NonDual 45+	
Captitation PMPM	\$ 643.00	Captitation PMPM	\$ 1,175.00	Captitation PMPM	\$ 825.00	Captitation PMPM	\$ 1,252.00
Actual Medical Expenditure	\$ 552.00	Actual Medical Expenditure	\$ 1,010.27	Actual Medical Expenditure	\$ 730.00	Actual Medical Expenditure	\$ 1,107.00
Quality Adjusted MLR Target	93.50%	Quality Adjusted MLR Target	93.50%	Quality Adjusted MLR Target	93.50%	Quality Adjusted MLR Target	93.50%
Actual MLR	85.85%	Actual MLR	85.98%	Actual MLR	88.48%	Actual MLR	88.42%
RM Pays back	\$ 49.21	RM Pays back	\$ 88.36	RM Pays back	\$ 41.38	RM Pays back	\$ 63.62
966		2725		13750		8381	
Dual		Dual- Medicaid Full/ Medicare Partial		AFDC/ CWP Adults 19+ M		AFDC/ CWP Adults 19+ F	
Captitation PMPM	\$ 104.00	Captitation PMPM	\$ 264.00	Captitation PMPM	\$ 324.00	Captitation PMPM	\$ 436.00
Actual Medical Expenditure	\$ 89.40	Actual Medical Expenditure	\$ 226.00	Actual Medical Expenditure	\$ 273.54	Actual Medical Expenditure	\$ 398.63
Quality Adjusted MLR Target	93.50%	Quality Adjusted MLR Target	93.50%	Quality Adjusted MLR Target	93.50%	Quality Adjusted MLR Target	93.50%
Actual MLR	85.97%	Actual MLR	85.61%	Actual MLR	84.43%	Actual MLR	91.43%
RM Pays back	\$ 7.84	RM Pays back	\$ 20.84	RM Pays back	\$ 29.40	RM Pays back	\$ 9.03
23554		1068		9863		40618	
BUYIN Working Adult Disabled		BC Women		Expansion Parent M		Expansion Parent F	
Captitation PMPM	\$ 1,086.00	Captitation PMPM	\$ 965.00	Captitation PMPM	\$ 324.00	Captitation PMPM	\$ 436.00
Actual Medical Expenditure	\$ 940.00	Actual Medical Expenditure	\$ 820.00	Actual Medical Expenditure	\$ 282.25	Actual Medical Expenditure	\$ 430.00
Quality Adjusted MLR Target	93.50%	Quality Adjusted MLR Target	93.50%	Quality Adjusted MLR Target	93.50%	Quality Adjusted MLR Target	93.50%
Actual MLR	86.56%	Actual MLR	84.97%	Actual MLR	87.11%	Actual MLR	98.62%
RM Pays back	\$ 75.41	RM Pays back	\$ 82.28	RM Pays back	\$ 20.69	RM Pays back	\$ -
480		3857		8114		27398	
AWDC							
Effective Capitation	\$ 530.00						
Actual Medical Expenditure	\$ 500.00						
Quality Adjusted MLR Target	93.50%						
Actual MLR	94.34%						
RM Pays back	\$ -						

Cohort	MMs	RM Owes	Actual Med. Expenditure
OAP A - NonDual	966	\$49.21	\$552.00
OAP B - SSI NonDual	2725	\$88.36	\$1,010.27
AND/AB - SSI NonDual <45	13750	\$41.38	\$730.00
AND/AB - SSI NonDual 45+	8381	\$63.62	\$1,107.00
DUAL	23554	\$7.84	\$89.40
DUAL - Medicaid Full/Medicare Pa	1068	\$20.84	\$226.00
AFDC/CWP Adults 19+ M	9863	\$29.40	\$273.54
AFDC/CWP Adults 19+ F	40618	\$9.03	\$398.63
BUYIN Working Adult Disabled	480	\$75.41	\$940.00
BC Women	3857	\$82.28	\$820.00
Expansion Parent M	8114	\$20.69	\$282.25
Expansion Parent F	27398	\$0.00	\$430.00
AWDC	58800	\$0.00	\$500.00
	199574		
Weighted Average		\$13.91	\$455.59
Aggregate Calculation			
		<i>Source</i>	
Total Cap	\$ 497.24	Accepted Payment Rate	
Actual Medical Expenditure	\$455.59		
Plan wide MLR	91.62%	Weighted average medical expenditure/ total cap	
Target MLR	93.50%	Quality Adjusted	
Rocky Owes	\$ 9.33	Rocky only owes if plan wide MLR is < target MLR. *	

EXHIBIT P, SAMPLE OPTION LETTER

Date:	Original Contract Routing # CMS #	Option Letter #	Contract Routing #
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- 1) **OPTIONS:** Choose all applicable options listed in §1 and in §2 and delete the rest.
- a. Option to renew only (*for an additional term*)
 - b. Change in the amount of goods within current term
 - c. Change in amount of goods in conjunction with renewal for additional term
 - d. Level of service change within current term
 - e. Level of service change in conjunction with renewal for additional term
 - f. Option to initiate next phase of a contract
- 2) **REQUIRED PROVISIONS.** All Option Letters shall contain the appropriate provisions set forth below:
- a. **For use with Options 1(a-e):** In accordance with Section(s) _____ of the Original Contract between the State of Colorado, Department of Health Care Policy and Financing, and Contractor's Name, the State hereby exercises its option for an additional term beginning Insert start date and ending on Insert ending date at a cost/price specified in Section _____, AND/OR an increase/decrease in the amount of goods/services at the same rate(s) as specified in Identify the Section, Schedule, Attachment, Exhibit etc.
 - b. **For use with Option 1(f), please use the following:** In accordance with Section(s) _____ of the Original Contract between the State of Colorado, Department of Health Care Policy and Financing, and Contractor's Name, the State hereby exercises its option to initiate Phase indicate which Phase: 2, 3, 4, etc for the term beginning Insert start date and ending on Insert ending date at the cost/price specified in Section _____.
 - c. **For use with all Options 1(a-f):** The amount of the current Fiscal Year contract value is increased/decreased by \$ amount of change to a new contract value of Insert New \$ Amt to as consideration for services/goods ordered under the contract for the current fiscal year indicate Fiscal Year. The first sentence in Section _____ is hereby modified accordingly. The total contract value including all previous amendments, option letters, etc. is Insert New \$ Amt.
- 3) **Effective Date.** The effective date of this Option Letter is upon approval of the State Controller or _____, whichever is later.

<p>STATE OF COLORADO John W. Hickenlooper, GOVERNOR Department of Health Care Policy and Financing</p> <hr/> <p>By: Insert Name & Title of Person Signing for Agency or IHE</p> <p>Date: _____</p>
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<p><u>ALL CONTRACTS REQUIRE APPROVAL BY THE STATE CONTROLLER</u> CRS §24-30-202 requires the State Controller to approve all State Contracts. This Contract is not valid until signed and dated below by the State Controller or delegate. Contractor is not authorized to begin performance until such time. If Contractor begins performing prior thereto, the State of Colorado is not obligated to pay Contractor for such performance or for any goods and/or services provided hereunder.</p>
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STATE CONTROLLER
Robert Jaros, CPA, MBA, JD

By: _____
 Insert Name of Agency or IHE Delegate-Please delete if contract will be routed to OSC for approval
 Date: _____